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Chemist+Druggist

news+education+tools for the pharmacy community

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1 March 2008



STAR APPEAL: **What awards can do for you**

See page 34



NORGINE

A woman with long dark hair is underwater, looking towards the camera with a slight smile. She is holding a large white cross-shaped sign. The sign has four words written on its arms in bold, black, sans-serif capital letters: 'STIMULATE' on the top-left arm, 'SOFTEN' on the top-right arm, 'LUBRICATE' on the bottom-left arm, and 'BULK' on the bottom-right arm. The background is a clear blue water.

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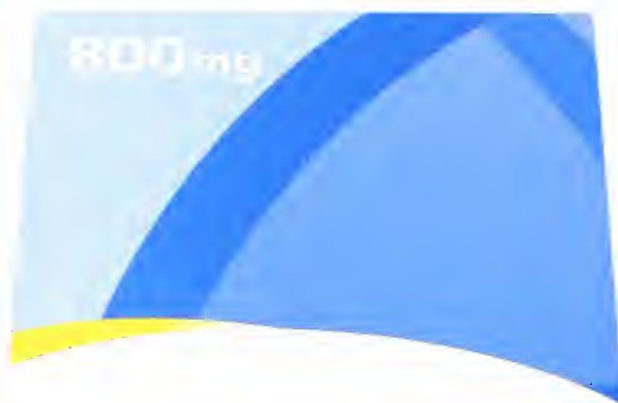
NEW

In moderately active ulcerative colitis:

Asacol[®]
goes from
Strength
to
Strength

Introducing NEW
Asacol 800mg MR tablets,
licensed up to 4.8g/day¹

Rx Asacol 800
by brand AND strength



Asacol[®] 800mg
MR tablets
(MESALAZINE)

Each modified release tablet
contains 800 mg mesalazine

Asacol[®] 800mg MR Tablets Abbreviated Prescribing Information

Presentation: Asacol 800mg MR Tablets, PL 00364/0083, each modified release tablet contains 800mg mesalazine (5-aminosalicylic acid). Product is supplied in plastic (HDPE) bottles containing 180 tablets (£124.86).

Indications: Ulcerative colitis. Treatment of mild to moderate acute exacerbations. For the maintenance of remission. Crohn's ileo-colitis. Maintenance of remission. **Dosage and administration:** Adults: Mild acute exacerbations: 3 tablets a day in divided doses. Moderate acute exacerbations: 6 tablets a day in divided doses. Maintenance of remission of ulcerative colitis and Crohn's ileo-colitis: Up to 3 tablets a day, in divided doses. **Elderly:** The normal adult dosage may be used unless renal function is impaired. **Children:** Not recommended. **Contra-indications:** A history of sensitivity to salicylates or renal sensitivity to sulfasalazine. Confirmed severe renal impairment (GFR less than 20 ml/min). Hypersensitivity to any of the ingredients. Severe hepatic impairment. Gastric or duodenal ulcer, haemorrhagic tendency.

Precautions: Use in the elderly should be cautious and subject to patients having a normal renal function. Discontinue treatment immediately if acute symptoms of intolerance occur including vomiting, abdominal pain or rash. Patients with the rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take this medicine because of the presence of lactose monohydrate. Standard haematological indices (including the white cell count) should be monitored repeatedly in patients taking azathioprine, especially at the beginning of such combination therapy, whether or not mesalazine is prescribed. Asacol should be used in extreme caution in patients with confirmed mild to moderate renal impairment. Renal function should be monitored (with serum creatinine levels, if available) prior to start of treatment, and periodically during treatment, taking into account clinical history & risk factors. Mesalazine should be discontinued if renal function deteriorates. If dehydration develops, renal fluid & electrolyte balance should be restored as soon as possible. Serious blood dyscrasias (some fatal) have been very rarely reported with mesalazine. Haematological investigations including a complete blood count may be performed prior to therapy initiation and immediately if the patient develops unexplained symptoms including pyrexia, myalgia, anaemia, haemorrhage etc. Stop treatment if suspicion or evidence of blood dyscrasia develops. Concomitant preparations which lower stool pH should not be concomitantly administered. Concurrent use with other immunosuppressive agents, e.g. NSAIDs & azathioprine, may increase risk of renal reactions. Mesalazine

should therefore be used with caution during pregnancy and lactation when the potential benefit outweighs the possible hazards in the opinion of the physician. If neonate develops suspected adverse reactions consideration should be given to discontinuation of breast-feeding or discontinuation of treatment of the mother. **Undesirable Effects:** Common: nausea, diarrhoea, abdominal pain, headache, vomiting, arthralgia/myalgia. Rare reports of leucopenia, neutropenia, agranulocytosis, aplastic anaemia, thrombocytopenia, myocarditis & pericarditis, peripheral neuropathy, vertigo, bronchospasm, eosinophilic pneumonia, pancreatitis, alopecia, lupus erythematosus-like reactions and rash (inc. urticaria), bullous skin reactions, abnormalities of hepatic function and hepatitis, interstitial nephritis and nephrotic syndrome with oral mesalazine treatment, usually reversible on withdrawal. Renal failure has been reported. Suspect nephrotoxicity in patients developing renal dysfunction. Drug fever. Very rarely, mesalazine may be associated with exacerbation of the symptoms of colitis, Stevens Johnson syndrome & erythema multiforme, interstitial pneumonitis. **Legal category:** POM. **Marketing Authorisation Holder:** Procter & Gamble Pharmaceuticals UK Ltd, Egham, Surrey TW20 9NW. Asacol is a trademark. © 2007 Procter & Gamble Pharmaceuticals. Refer to Summary of Product Characteristics before prescribing. Date of preparation November 2007 AS7555.

Reference:

1. Asacol 800mg MR tablets Summary of Product Characteristics, September 2007
Date of Document Preparation January 2008. AS7609/55578.20

Adverse events should be reported to Procter & Gamble Pharmaceuticals
UK Ltd on 01784 474900. Information about adverse event reporting can
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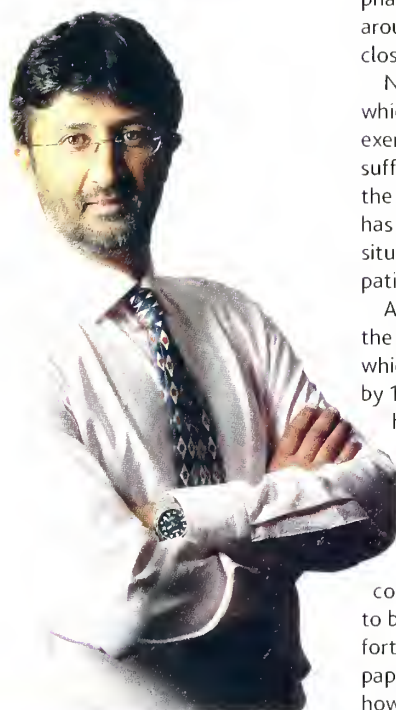
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Chemist+Druggist

news education tools

Comment from the Editor



Despite pharmacy's reticence, the idea behind 100-hour pharmacies was a laudable one: better access to medicines and healthcare advice. However, it's fair to say that their introduction has been anything but successful.

With no real restrictions on where they are sited, 100-hour pharmacies have sprung up around the country, sometimes in close proximity to each other.

Neighbouring pharmacies, which in many cases provided an exemplary service locally, have suffered financially. And globally, the total pot of pharmacy cash has been spread more thinly. A situation that benefits neither patients nor pharmacy.

And while PCTs have had the opportunity to specify which services should be provided by 100-hour businesses, they have hardly been inspiring in their choice.

On balance, it was a good idea, but one that has been badly executed. So the latest government review of control of entry, which is likely to be published alongside the forthcoming pharmacy white paper, has much to resolve. Quite how it will improve access

without impacting significantly on the existing pharmacy network remains to be seen.

But perhaps there is an effective solution, as our story on using pharmacy premises to host dental hygiene clinics (p8) shows.

The existing network remains woefully under-utilised and the introduction of pharmacy-based national services such as dental clinics, minor ailments, smoking cessation, health screening or even in-store out-of-hours medical services, would offer huge benefits to the NHS, the public and the profession itself.

Whether or not the white paper on community pharmacy will go this far is anyone's guess, but we know the status quo needs work. Yes, some degree of entry restriction is needed to give contractors stability and to allow PCOs to develop an integrated service. But the current halfway house is clearly not the solution.

C+D will be examining control of entry in the coming weeks and if you have been affected, whether adversely or otherwise, we want to hear from you.

Email your views to haveyoursay@cmpmedica.com
Gary Paragpuri, Editor

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100-hour row hits Westminster

MP demands explanation for 'totally wrong' exemption that threatens small pharmacies

Zoe Smeaton

Concerns about 100-hour

pharmacies went all the way to Parliament this week, backed by an MP who told C+D the exemption rules were "totally wrong".

Simon Burns MP asked the government to justify the 100-hour exemption, which he said could put many small family-run pharmacies out of business.

The MP was spurred on by his constituent Maurice Waldman, whose pharmacy in Chelmer Village, near Chelmsford, is threatened by a possible 100-hour opening. Mr Burns demanded the government urgently review the regulations.

The Galbraith review on control of entry exemptions is now complete, a government spokesperson said. But the review will not be released until the pharmacy white paper is also ready. Mr Burns responded:

"There is no point in having a review, sitting on it for months and then deciding what to do, when in that time lots of small pharmacies could have gone out of business."

Waldmans Pharmacy could lose half its prescription business to the 100-hour opening planned by a nearby Asda, Mr Waldman warned. He said: "It's good that there is more choice available, but if I can't compete then what choice will there be?"

John Stanley, LPC secretary for the Essex region, said several 100-hour applications had been



Maurice Waldman and staff members Lisa Wilson (centre) and Maggie Clarke with petitions against the Asda opening

filed in the area, and he said the government review was "long overdue".

Pharmacy industry experts, including the NPA and the Independent Pharmacy Federation, have expressed fears over the 100-hour exemptions, which force PCTs to approve applications from contractors willing to open for 100 hours per week.

Should the 100-hour rule be scrapped? Email zsmeaton@cmpmedica.com

Exemption fuels Asda growth bid

Asda plans to open 53 more pharmacies this year, the majority under 100-hour contracts.

John Evans, superintendent pharmacist at Asda, told C+D this will bring the total number of Asda pharmacies to 100.

Mr Evans said: "Our plan is to get a pharmacy in every store." He added that the sites for 42 of the pharmacies had already

been pencilled in with dates. Several will be around the London and coastal areas in the south of England, he added.

The expansion could create up to 200 pharmacy jobs, with both full and part-time pharmacists needed. Mr Evans said: "Customers tell us they want 100-hour pharmacies and pharmacies in supermarkets."

ASDA
WAL-MART

Sainsbury's is first with in-store GP

A Sainsbury's store in North

West England has become the first supermarket to offer an in-store GP surgery.

The service will run from the consultation area of a 100-hour Sainsbury's pharmacy at the branch in Heaton Park, near Manchester.

The surgery will provide out-of-hours care on weekdays and Saturdays under a six month trial to improve access to GPs in the area.

The scheme received a frosty response from nearby pharmacists.

Ian Short, secretary of Bury & Rochdale LPC, said: "We need to learn to live with it and work alongside it and to compete with it, to the benefit of the public."

Mr Short said he had no immediate concerns about the impact on local pharmacists as the site was around a mile away from the nearest outlet. **RF**

Fresh crystal meth conviction

Pharmacists received another stark reminder to scrutinise sales of flu remedies this week as a man was sentenced for manufacturing crystal meth in Derbyshire.

The police said no pharmacy-bought pseudoephedrine or ephedrine was involved in the case, in which the man received a suspended sentence. But experts have urged caution.

Rob Darracott, chief executive of the Company Chemists' Association, said: "Any news about home production of this nasty drug is bad news... this is no cause for complacency."

Authorities attempted to remove drugs such as Lemsip and Beechams from pharmacies in 2007 over fears illicit sales could fuel a crystal meth epidemic.

Mr Darracott said training programmes such as MethGuard UK, recently updated to cover changes in the law restricting pack sizes from April, could help.

Roger Walker, chairman of the Commission on Human Medicines' working group set up to monitor the crystal meth situation, said the group would meet in April and was "keeping an eye on activity levels". **ZS**

Industry fights red tape threat

Pharmacists face extra admin over proposals on safeguarding vulnerable groups

Zoe Smeaton

Industry bodies have united against government proposals to subject pharmacists to yet more regulation.

A consultation on safeguarding vulnerable groups has set out a scheme to regulate individuals who perform certain activities involving vulnerable adults or children. In the proposal, people receiving healthcare are described as vulnerable, meaning pharmacists could fall under the measure.

Under the scheme, regulated individuals would need to register with the Independent Safeguarding Authority (ISA), which can bar individuals where necessary.

Applying to register with the ISA would take time, and also cost an as yet undecided fee. Steve Lutener, head of regulation at PSNC, told C+D he feared this could put extra pressure on pharmacists, who are already regulated by the RPSGB. He said: "It would be an administrative burden which isn't really necessary... it's not going to

provide any extra safeguards."

The consultation closed last week, and the NPA, CCA, RPSGB, AIMp and PSNC returned a joint response to the ideas. They said the Society's regulation of the profession provides enough protection for the public, and called for pharmacists to be excluded from the scheme to avoid duplication of regulation.

A Department for Children Schools and Families spokesperson said all consultation responses would be considered.

Links are poor, Lord Darzi told

There are insufficient local links between the ongoing review of the NHS and the profession, pharmacists have told Lord Darzi.

At a pharmacy engagement event for his NHS Next Stage Review, Lord Darzi encouraged delegates to contact the eight clinical working groups informing it. "Please engage at a local level," he said.

But Croydon LPC chief officer Andrew McCoig asked: "Why do I have to go out and find them? Why do I not get an invitation, as a right, to contribute?"

When Lord Darzi asked if this was a local problem, shouts of "universal" came from the floor of the event, held at the RPSGB headquarters on Wednesday.

He told delegates the Department of Health would provide them with the names of the working group chairs, and suggested pharmacists invite the chairs to visit their practices.

The pharmacy white paper has been delayed in order to dovetail with Lord Darzi's review, the DH has said. JR

Gale goes down a storm



MP Roger Gale (left) caught up with his local pharmacist Keith Howell (right) in the second Building Bridges visit last week.

The Conservative MP took to the scales for an obesity test during the visit to the Delmergate Pharmacy at Beltinge, Kent.

Mr Gale said: "I'm a great fan and champion of the community pharmacist and always have been."

Mr Howell said: "I was really happy with it. I was surprised how clued up he was on pharmacy services."

Twenty six pharmacists have now signed up to the Building Bridges campaign that aims to get as many MPs as possible to visit their local pharmacy.



Sign up to the Building Bridges campaign at:
www.chemistanddruggist.co.uk/buildingbridges

News in brief

Enhanced service rates

A 4 per cent rise in indicative rates for national enhanced services in Wales has been agreed. The rates, for 2007-08, become operative from March 1, and contractors who have been offering services since April 1, 2007, should receive back payments. For more information go to www.chemistanddruggist.co.uk

Celebrating Simon

A celebration of Simon Colebeck's life will be held on April 18 at the Walkers Stadium in Leicester. The event will include some "typical Simon memories" from colleagues and friends of the former Numark managing director, who died of cancer last November. Please contact Amanda Haddock on 01827 841214 to attend.

Nice guides available

Nice issued clinical guidelines on smoking cessation services, and the management of irritable bowel syndrome, osteoarthritis and prostate cancer this week. For more information, go to www.chemistanddruggist.co.uk/clinical

Depression study

Depressed patients do not benefit significantly from taking selective serotonin reuptake inhibitors, authors of a meta-analysis have claimed. For the full story go to www.chemistanddruggist.co.uk

Alphega appointment

Alphega, the UniChem virtual chain launched in the UK last November, has appointed a business manager to liaise with interested independent contractors. The brand's UK website has also been unveiled. www.alphega-pharmacy.co.uk



Read Bon Vivour at
www.chemistanddruggist.co.uk/opinion

C+DAWARDS 08

Don't miss your chance to
win the holiday of a lifetime
worth £3,500.

See p32 to 35 for details.
Closing date March 14

Dispensary TALK

Would you join a pharmacy trade union covering employees and contractors?



"I would be more likely if it would cover both employees and contractors but it would have to demonstrate it was of benefit."

Mark Collins, Cornwell's Chemist, Stafford



"To introduce another tier of negotiation would potentially detract from future developments. We've enough bodies as it is and I'm not clear on the benefits."

Linda Bracewell, Baxenden Pharmacy, Accrington

WEB VERDICT:

Yes: ☒ 74%

No: ☐ 26%

Armchair view: Strong support for a new overarching union, but significant numbers of you have reservations that you don't want to hand Tom, Dick or Arthur over to looking after your affairs.

This week: Would you want a dental clinic at your pharmacy? Vote online at www.chemstandards.org.uk

Tory MP: use pharmacy to solve dental crisis

Hygiene clinics would address problem of patients with no access to dental care

Colin Brown/Jennifer Richardson

The Conservatives are proposing to allow community pharmacies to run clinics for dental hygienists.

Tory health spokesperson Mike Penning told C+D he would scrap the law under which patients have to get a referral from a dentist to see a dental hygienist from "day one" of taking office.

"It would be entirely up to the businesses themselves, but I would like to see Boots or Lloyds using their premises to offer clinics by dental hygienists," said Mr Penning.

Making clinics available on the high street would tackle the failure of the government to provide dental care for over a million patients who cannot get on NHS dental lists, he said.

Pharmacy reacted cautiously to the proposal. Independent Pharmacy Federation chairman Fin McCaul said: "Any service pharmacy can take on board is a benefit." But he added the investment level could prove prohibitive in this case.

CCA spokesperson Georgina Craig said its members would consider the suggestion "like any investment



Open for business: placing hygienists in community pharmacies would improve access to dental care

decision", while spokespersons for both the NPA and Lloydspharmacy said more details were required. Boots was unable to comment as C+D went to press.

A Department of Health spokesperson said: "We are

working hard to increase access to NHS dental care professionals."

Would you welcome a dental clinic?
jrichardson@cmpmedica.com

Avicenna profits top £1million as CEO lauds member loyalty

Avicenna has attributed record profits approaching £1.2 million to member support.

In its 2007 chairman's report, the buying group revealed a 15th successive year of growth, with net profit increasing 23 per cent to

more than £1m for the first time.

Membership rose by 100 to more than 650. But chief executive Salim Jetha said the "crucial" factor was member loyalty.

"It's not just a numbers game," he said. "It depends

how much support they give us."

Members will be rewarded with a total shareholder distribution of £1.75m after Avicenna made a further £820,000 available.

Mr Jetha's former chairman role has been split into a CEO position and a non-executive chairman post filled by David Gratton, a non-executive director at Avicenna for four years.

One of Mr Gratton's tasks will be to consider stock market flotation, a prospect first broached at Avicenna's 2006 annual conference.

The location of this year's Avicenna conference has changed to Zanzibar, Tanzania, due to continuing unrest in Kenya. **JR**

Avicenna results by numbers

The buying group's net profit

New members

Consecutive years of growth

Total cash paid out to shareholders

THE **POWER** TO HELP THEM QUIT.^{1,3}



- **First-in-class oral prescription therapy with a unique dual action:**^{1,2,4}
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 - Antagonist action: Reduces the satisfaction associated with smoking⁴
- **Significantly higher quit rate vs. bupropion or placebo at 12 weeks**^{1,2,5}
- **Favourable safety and tolerability profile in approximately 4,000 treated smokers**⁶

¹ Based on the Minnesota Nicotine Withdrawal Scale (MNWS), Brief Questionnaire of Smoking Urges (QSU-brief) and modified Cigarette Evaluation Questionnaire (mCEQ)

CHAMPIX® Film-Coated Tablets (varenicline tartrate) ABBREVIATED PRESCRIBING INFORMATION – UK. (See Champix Summary of Product characteristics for full Prescribing Information).

Please refer to the SmPC before prescribing Champix 0.5 mg and 1 mg. **Presentation:** White, capsular-shaped, biconvex tablets debossed with "Pfizer" on one side and "CHX 0.5" on the other side and light blue, capsular-shaped, biconvex tablets debossed with "Pfizer" on one side and "CHX 1.0" on the other side. **Indications:** Champix is indicated for smoking cessation in adults. **Dosage:** The recommended dose is 1 mg varenicline twice daily following a 1-week titration as follows: Days 1-3: 0.5 mg once daily, Days 4-7: 0.5 mg twice daily and Day 8 – End of treatment: 1 mg twice daily. The patient should set a date to stop smoking. Dosing should start 1-2 weeks before this date. Patients who cannot tolerate adverse effects may have the dose lowered temporarily or permanently to 0.5 mg twice daily. Patients should be treated with Champix for 12 weeks. For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment at 1 mg twice daily may be considered. Following the end of treatment, dose tapering may be considered in patients with a high risk of relapse. **Patients with renal insufficiency:** Mild to moderate renal impairment: No dosage adjustment is necessary. Patients with moderate renal impairment who experience intolerable adverse events: Dosing may be reduced to 1 mg once daily. Severe renal impairment: 1 mg once daily is recommended. Dosing should begin at 0.5 mg once daily for the first 3 days then increased to 1 mg once daily. Patients with end stage renal disease: Treatment is not recommended. **Patients with hepatic impairment and elderly patients:** No dosage adjustment is necessary. **Paediatric patients:** Not recommended in patients below the age of 18 years. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Warnings and precautions:** Effect of smoking cessation: Stopping smoking may alter the pharmacokinetics or pharmacodynamics of some medicinal products, for which dosage adjustment may be necessary (examples include theophylline, warfarin and insulin). Smoking cessation may result in an increase of plasma levels of CYP1A2 substrates. Smoking cessation, with or without pharmacotherapy, has been associated with the exacerbation of underlying psychiatric illness (e.g. depression). There is no clinical experience with Champix in patients with epilepsy. At the end of treatment, discontinuation of Champix was associated with an increase in irritability, urge to smoke, depression, and/or insomnia in up to 3% of patients, therefore dose tapering may be considered. **Pregnancy and lactation:** Champix should not be used during pregnancy. It is unknown whether varenicline is excreted in human breast milk. Champix should only be prescribed to breast feeding mothers when the benefit outweighs

the risk. **Driving and operating machinery:** Champix may have minor or moderate influence on the ability to drive and use machines. Champix may cause dizziness and somnolence and therefore may influence the ability to drive and use machines. Patients are advised not to drive, operate complex machinery or engage in other potentially hazardous activities until it is known whether this medicinal product affects their ability to perform these activities. **Side-Effects:** Adverse reactions during clinical trials were usually mild to moderate. Most commonly reported side-effects were abnormal dreams, insomnia, headache and nausea. Commonly reported side-effects were increased appetite, somnolence, dizziness, dysgeusia, vomiting, constipation, diarrhoea, abdominal distension, stomach discomfort, dyspepsia, flatulence, dry mouth and fatigue. See SmPC for less commonly reported side-effects. **Overdose:** Standard supportive measures to be adopted as required. Varenicline has been shown to be dialyzed in patients with end stage renal disease, however, there is no experience in dialysis following overdose. **Legal category:** POM. **Basic NHS cost:** Pack of 25 11 x 0.5 mg and 14 x 1 mg tablets Card (EU/1/06/360/003) £27.30, Pack of 28 1 mg tablets Card (EU/1/06/360/004) £27.30, Pack of 56 0.5 mg tablets HDPE Bottle (EU/1/06/360/001) £54.60, Pack of 56 1 mg tablets HDPE Bottle (EU/1/06/360/002) £54.60, Pack of 56 1 mg tablets Card (EU/1/06/360/005) £54.60. Not all pack sizes may be marketed / marketed at launch. **Marketing Authorisation Holder:** Pfizer Limited, Sandwich, Kent, CT13 9NJ, United Kingdom. **Further information on request:** Pfizer Limited, Walton Oaks, Dorking Road, Tadworth, Surrey KT20 7NS. Last revised: 10/2007

Adverse events should be reported to Pfizer Medical Information on 01304 616161. Information about adverse event reporting can also be found at www.yellowcard.gov.uk

For further information, please contact Pfizer Medical Information on 01304 616161 or email medinfo.uk@pfizer.com

References: 1. Gonzales D *et al.* JAMA 2006; 296:47-55. 2. Jorenby DE *et al.* JAMA 2006; 296:56-63. 3. Tonstad S *et al.* JAMA 2006; 296:64-71. 4. Coe JW *et al.* J Med Chem 2005; 48:3474-3477. 5. Gonzales DH *et al.* Presented at 12th SRNT, 15-18th Feb, 2006, Orlando, Florida. Abstract PA9-2. 6. CHAMPIX Summary of Product Characteristics.



Date of preparation: November 2007 CHA354a

CHAMPIX
varenicline tartrate

News in brief

Asbestos video warning

The government's Health and Safety Executive has launched a web video warning tradesmen about the dangers of asbestos. The release marked Action Mesothelioma Day on Wednesday, February 27, as part of HSE's Hidden Killer campaign.

www.hse.gov.uk/asbestos

Chronic pain control

Three-quarters of patients who completed a pharmacy and physiotherapy-led chronic pain management programme adjusted their medication to provide better pain control, an evaluation has shown. Two additional pharmacists are currently being trained for an expansion of the Fife Rivers initiative.

NAWP seeks mentors

The National Association of Women Pharmacists is seeking voluntary mentors to offer friendly support to people likely to be moving or returning to community pharmacy. For more information contact Christine Heading at enquiries@nawp.org.uk

Diabetes undetected

Tens of thousands of people with diabetes could be going undiagnosed, according to research published in the British Journal of General Practice. A survey of blood glucose measurements in the records of 3.6 million patients found 3,758 patients could have the condition but be unaware of it.

www.chemistanddruggist.co.uk

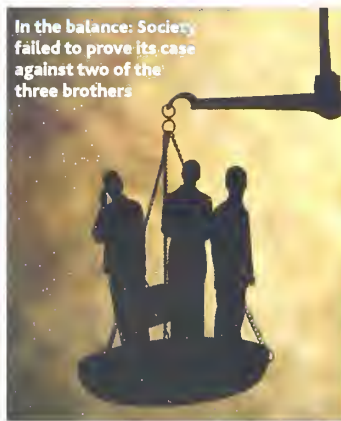
Update MCQs

This week's issue contains the questionnaire for February's Pharmacy Update modules on nail problems, insomnia and glaucoma. The C+D CPD programme is accredited by the College of Pharmacy Practice, with MCQs and a telephone marking service backed by Genus Pharmaceuticals. Previous modules and test papers are available at

www.chemistanddruggist.com/uk/update. For more information or to register call: 01732 377269.

RPSGB pays for legal defeat

Partial costs awarded in 'significant case'



In the balance: Society failed to prove its case against two of the three brothers

Rob Finch/UKL

A landmark ruling will force the Royal Pharmaceutical Society to pay up to £20,000 legal costs to two brothers who had misconduct cases against them dismissed.

Judge Mota Singh, chairman of the RPSGB disciplinary committee, ordered the payment because the Society failed to specify what the men did wrong.

The ruling is the first time the RPSGB has had to pay costs to pharmacists for unnecessary proceedings since legislation was amended last year.

The Society took disciplinary action after allegations of incorrect

prescription endorsement at the Laurel Pharmacy in Kingston.

Co-owners Lalit and Bhagyachandra Tanna faced charges despite having no say in the running of the business. This was left in the hands of their other brother Ashokkumar Tanna, who was reprimanded over the incident.

David Reissner, partner at law firm Charles Russell, who represented the brothers, said: "I think it's a significant judgement as it's the first in which an order has been made, but also one hopes the Society will recognise that they are accountable in a way they weren't before."

The Society said it would "take some time to consider the implications of the decision". It was "too early" to comment further at this stage, the RPSGB added.

The total bill for legal costs will be assessed by an independent adjudicator if it cannot be mutually agreed.

The three brothers had originally sought £200,000 in fees. However, Judge Mota Singh said the allegation against Ashokkumar Tanna had been justified and refused his claim. He ordered the Society to pay 20 per cent of the legal bill of the other brothers.

Assura wins appeal case against contract application

Assura Pharmacy has won a High Court appeal against the NHS's rejection of a contract application.

Two other appeals were dismissed. The case was hailed an "important decision" on choice of pharmaceutical services in contract considerations.

Assura challenged decisions by the NHS Litigation Authority's Family Health Service Appeal Unit to refuse the company entry to pharmaceutical lists in Tunbridge Wells, Kent; Freckleton, Lancashire; and Todmorden, West Yorkshire.

Judge Gary Hickinbottom upheld the challenge in relation to Freckleton, finding that the NHLA's Pharmaceutical Appeals

Committee "did not engage with the issue of choice at all". But the Todmorden challenge, also on the issue of choice, was rejected.

Healthcare solicitor Noel Wardle, of Charles Russell, said: "This important decision gives guidance on how PCTs and the Appeal Unit should approach the question of choice." Assura business development director Conor Daly also welcomed the guidance, but said further clarity on control of entry was needed. **Strand/JR**



Pub swaps drinks for dispensing

A pharmacy in Radford, Nottingham, is planning to expand the business by moving into a local pub.

Alan Close, managing director of Burrows and Close Pharmacy, said the Wheatsheaf Inn offered a prime spot near the local GP surgery.

He said: "It's a lot bigger, we're going to be able to have two consultation rooms and we're thinking about renting them out to therapists."

But, Mr Close admits, it won't be an easy task to convert the former boozer once planning permission goes through.

"It's in a hell of a state – walls need moving and new structures [erected] so we'll be able to offer a pharmacy business."

The project could cost up to £250,000, he predicted.

Mr Close plans to celebrate the building's previous guise by adopting a pub theme when naming the consultation rooms. **EW**

The Whie Coat Arms? The Pestle & Mortar? What should Alan name his rooms? Email your entries to mgosney@cmpmedica.com and win a C+D mug

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Building blocks



Once you've set a date with your local MP – then what? **Jennifer Richardson** has 10 steps to a successful Building Bridges visit

1. Plan ahead

Decide what you are going to talk to your politician about in advance – and remember that less is often more. "Don't bombard your MP with too many different issues – just use one or two that you feel strongly about," advises pharmacist Keith Howell of Delmergate Ltd, Kent, who was visited by Roger Gale MP in Building Bridges' second visit.

If you're stuck for ideas, Alex MacKinnon – who meets up to three politicians a month in his role for Community Pharmacy Scotland – suggests pharmacy's potential in public health and chronic disease management, as well as the need for appropriate access to the electronic patient care record.

It goes without saying that you should know his or her name – and how to pronounce it properly. But it's often said that it's not what you say, it's how you say it. And that's why Michael Reynolds – superintendent of Hampshire's AR Pharmacy, who was visited by Sandra Gidley MP (pictured above right) in Building Bridges' first visit – believes you also need to make sure you know which party they represent.

"If it's a Labour MP, you've got to focus on the positive," he says, "and then add your bit as to what could be better."

With opposition MPs, Mr Reynolds believes, you can afford to be a bit more critical.

3. Brief your staff

So, you know what you're going to say, who you're saying it to, and how you're going to say it. But you also need to make sure you've passed this information on to any pharmacy staff your politician is likely to encounter on his or her visit, so that they receive a coherent message. "It's important that, before [the politician] comes in, all the staff are briefed," says Lloydspharmacy pharmacy director Andy Murdock.

Politicians are extremely busy so your visits are likely to be dictated by their diaries but, if you can, choose a time according to your pharmacy's working day and week. As Mr Murdock says: "You don't want [your politician] turning up at 11 o'clock when all your scripts have just arrived from the surgery."

5. Location, location, location

The setting for your meeting can be just as important in minimising distractions. Mr Reynolds says: "Go somewhere that's a bit quiet where you're not going to be interrupted." A back room, office, or consultation room could all be good options.

"It's very important to engage with ministers in a positive manner," says Robbie McGregor, director of Scottish pharmacy chain Lindsay & Gilmour. "Coming along with a long list of complaints is not the way to go about it." The message: no one likes a whiner. As Mr Reynolds sums it up: "You mustn't be a moany old pharmacist – they won't want to know."



7. Court publicity

"If an MP makes a visit, they want to get something in the local press," says Mr Murdock. And your pharmacy could also benefit from the publicity, so tell your local newspaper about your politician's visit and make sure there's someone on hand to take photographs. Mr Murdock suggests agreeing a joint press release with your politician's office, preferably drafting an outline before the visit actually takes place, so that it can be completed and sent to the local press as soon as possible after the event.

It may seem obvious, but basic hospitality such as offering refreshments can go a long way. Mr Reynolds says: "Have a quick tour of the facilities... and then have a cup of tea."

9. Maintain your bridge

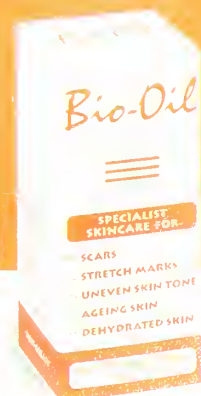
The same old-fashioned courtesy also applies after the visit is over. "Follow up with a letter saying: 'Thank you for coming,'" Mr Murdock recommends. And don't stop there. Mr Howell intends to invite his MP back to visit Delmergate Ltd's newly refurbished branch once it reopens. Mr Howell says: "Once the bridge is there, let's use it and build on that, and keep local MPs abreast of what's happening in pharmacy so it's in the back of their minds all the time."

Finally, if all the dos and don'ts send you into a blind panic, relax. "Just be yourself," says Mr Howell. "We're all doing a great job and I'm sure that [politicians] will see that."





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*The Thinking Shop, 2006

[†]Photobiology Laboratory MEDUNSA, 2006



Letters

Please email us with your letters to:

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Or write to the Editor at:

C+D, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE

Why are we being mandated to perform checks for free?

I would like to raise awareness of yet another example of how pharmacists are being undervalued.

From April 1, I will be expected, as a matter of course, to play a role in improving the safety of anticoagulant prescribing. This is a laudable step, as finally we are being acknowledged as front-line troops in the battle against poor prescribing. I wholeheartedly support the aims of this guidance.

What I and many other pharmacists do not accept is that this small gesture made by the National Patient Safety Agency (NPSA) will have consequences for my working day, stretching my already thinly spread time even further, compromising the safety of other patients because the government has stolen the moral high ground, urging us to do this in the interests of patients, as healthcare professionals.

What nobody seems to have realised is that it is going to take, approximately, a minimum of five minutes per patient to ensure that I am complying with this guidance. Five minutes, in the interests of patient safety? Not a big price to pay?

Well, on an individual basis it may not be, but take into account the fact that my pharmacy has 75 patients receiving warfarin every month. That is an awful lot of five minutes... 375 of them to be exact, or over six hours a month, spent chatting to patients about

the ins and outs of anticoagulant therapy. I and many of my colleagues will be more than happy to do this, but how is my employer (who has around 50 pharmacies) going to be reimbursed for this wonderful use of my time?

How many five minutes am I up to now? That's 312 hours a month, or 3,750 pharmacist hours over the entire year for our company. That is until we hit a snag, have to counsel

the cracks in the system? You can almost hear the GP's lawyer saying: "It was the pharmacist's responsibility to check" whenever something goes wrong. Well if I am taking on the responsibility it is only right that my employer is reimbursed for his extra risk. A per capita payment, say £5 per patient receiving anticoagulant therapy, would be a reasonable start, with extra payments to cover the other

the PCT commissioning lead, when presented with a fully costed version of this guidance... "Why should we pay for it? We're getting it for free now."

Is there a moral case against paying us to improve drug safety? If you needed proof of principle, GPs are paid for drug safety monitoring, with, for example, DMARDs, my local GP practice, receiving a per capita payment for every patient on their list. I believe this is part of a locally enhanced service for our area. Why is there no top down thinking?

Why is there an MUR fund, and not an advanced service fund? No two pharmacies are exactly the same, from mine, a small health centre pharmacy with no scope for a consulting room, to a large city centre pharmacy with little continuity in terms of patient care. Why are we made to compete for the same theoretical pot of money, which the DH knows neither of us can achieve?

The contract as it stands is not a winner for those of us that have to implement it, but with some imagination it could so dramatically improve patient care, reduce waste and offer the NHS unbeatable value for money. So where are our champions?

My slogan for now is "no more unfunded mandates".

Mike Hewitson
Saintbridge Pharmacy
Gloucester

If I am taking on the responsibility, it is only right that my employer is reimbursed for his extra risk

about an interaction, provide more information or chase up some unforeseen query.

Why are we being mandated to perform checks for free? A conservative estimate for the amount of time it will take me to implement this guidance in my pharmacy alone is, according to the figures I have laid out, about £150 a month. This is the perfect example of a service, provided through pharmacy, which benefits patients but where is the recognition that we are being asked to take a portion of the liability if a patient slips through

recommendations made by the NPSA.

Surely we finally have the DH over a barrel? Its own agency has mandated this level of support, so what is the argument against funding this service properly? There is only one: the DH, PCTs and the NPSA believe that we will all have to tow the line and offer this free of charge; they believe that they can bully pharmacy into a corner over this, and virtually any issue. Let me make this clear: once something has been offered free of charge it is very difficult to put the genie back in the bottle. Imagine

PSNC can use your experiences to negotiate with the DH



Alastair Buxton, head of NHS Services, PSNC, replies:

Compliance with the recent NPSA guidance on anticoagulant therapy will hopefully improve the safety of this type of therapy; clearly it is important that community pharmacy engages with this new process in order to protect patients from harm.

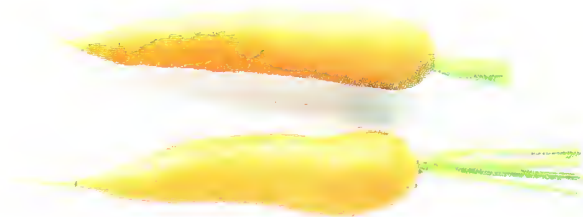
Mr Hewitson raises an important point about the cost of implementing the NPSA

guidance and it is one that PSNC discussed early last year when the draft NPSA guidance was released for comment by stakeholders.

As part of the funding formula for the community pharmacy contract, new regulatory burdens, such as additional monitoring of anticoagulant patients, are considered in annual negotiations with the Department of Health.

New costs are considered on a retrospective basis in order that an

evidence base for the new cost can be collated. PSNC is currently in the process of requesting information on the cost of the new NPSA guidance from a range of contractors; this will then be used in forthcoming negotiations. If any pharmacy contractors have assessed the increased cost to their business of this NPSA guidance they are welcome to send the details to me at alastair.buxton@psnc.org.uk



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Not the smartest card in the pack

A screen alert warning me when my smartcard is about to expire (C+D February 23, p6) is a clever bit of technology that will no doubt come in useful if EPS ever truly gets off the ground. My smartcard is bound to expire just as release two goes live, which will be the first time I ever really need to use the damn thing.

It's no bad thing that EPS has probably been one of the most delayed implementation programmes ever conceived, because there are still so many teething problems to be sorted. Luckily there is still plenty of time for someone to figure out how cards will be renewed when our warning alert does pop up.

Pulse magazine has claimed that over 6,000 smartcards have already gone missing. NHS Connecting for Health revised that figure down to 4,147, but that's still around 1 per cent of the 400,000 issued. Somebody should be worried that they are being treated so contemptuously.

My smartcard rarely sees the light of day so I would have to be careless enough to mislay my whole wallet to lose it. But once we start using these cards every day many more will be lost or



stolen. And they will never be as well looked after as credit cards because they are not as personal.

Smartcards are supposedly not much use without a PIN, but some bright sparks will have their number in their wallet alongside their card, and some even brighter crooks will be able to access the system anyway. Banks can afford to replace money stolen using a credit or debit card, but once someone has accessed your personal information the damage has been done.

There is no way that patient records accessed by thousands of NHS workers from thousands of locations in this way can ever be completely secure. Perhaps we should all just accept this.

Recent revelations about just how careless the government is with personal information reveal that we'd all been tricked into thinking it was secure in the first place.

We should accept that more damage is likely to be done by a pharmacy unable to dispense prescriptions than by a few people peeking at others' medical records. The sensible thing to do would be to give us all a 'spare' card, or a 'pharmacy' card to be kept in the CD cupboard for emergency use.

Irish eye

Terry Maguire

Hocus-pocus?

Always one for writing letters of complaint, I spent some time in therapy and now find I can keep my fingers off the keyboard even when the most irritating of issues bite. Yet recently I fell off the wagon, overpowered as I was by a compulsion stronger than me and I wrote to the Ulster Chemists' Association (UCA).

My complaint was in response to a flyer they sent inviting me to a training event. What so incensed me was the topic: Homotoxicology and Anti-Homotoxic Therapy. A seductive title for any aspiring scientist and a must-attend event for those wishing to keep at the leading edge but on further consideration the topic appears to be just a new term for homeopathy.

So in my letter to the UCA I outlined my concerns and it goes something like this: "At a time when community pharmacy is taking huge strides to be recognised as a key player in the primary healthcare team it is disappointing to me that one of our main representative organisations – the UCA – is aligning itself with an arcane practice, with no scientific basis whatsoever. I can only describe this impressive sounding technology as nonsense." I was unhappy so I went on.

"This modern version of homeopathy or

nano-pharmacology is, like old-fashioned homeopathy, nothing more than an expensive placebo effect. If community pharmacists are to be accepted as true scientists in a modern society then we need to be honest with our patients about this." I was getting into my stride.

"I'm not a Luddite or a kill-joy," I reasoned, "I accept that money is to be made from the sale of homeopathic products and I as much as anyone know that pharmacies are commercial operations. Yet to paint this fiscal benefit as anything more than profit is to do a disservice to the heritage of our proud profession." I was getting very passionate indeed; so I went on.

"Complementary therapy and alternative medicine," I continued at a pace, "are fashionable; there is a tendency to assume efficacy with no ill effects yet this is scientifically untrue and community pharmacy should not be endorsing

this position." Was that a split infinitive I thought to myself?

"A further concern," I told them, "was that other healthcare professionals – doctors and dentists – were invited to the event. At best they will laugh at us and at worst use it against us when we suggest that we want to provide a new, genuine service. We need to focus on medicines management, smoking cessation and innovative services within the Building the Community Pharmacy Partnership."

The president graciously and politely responded, saying he was delighted to get my letter but the Committee having discussed it "remained open-minded on [nano-pharmacology]". He went on to say that the UCA strives to provide "informative and thought-provoking training or educational seminars". More importantly, he had received letters of support for staging this event. So there we have it; the scientific method is now a democratic process; scientific facts are no longer researched in randomised controlled double-blind studies, they are just voted on like an X Factor contestant. I can't wait for the UCA's next training event which might be Public Health and Astrology.

Terry Maguire is a community pharmacist in Northern Ireland

Do you agree with Terry?
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Pharmacist prescribing: 'time is right' for ideas

Fiona Salvage reports on the highlights from a National Prescribing Centre conference for non-medical prescribers

Around 200 non-medical prescribers (NMPs) heard that the "time is right for bringing [their] ideas forward", at a conference organised by the National Prescribing Centre in London last month.

Conference chairwoman June Crown led the call to arms ahead of a

programme of speakers who addressed the headline topic of driving service redesign. Speakers at the conference emphasised the need to do things differently to get better results, and highlighted the importance of support networks for non-medical prescribers.

James Kingsland

Chairman of the National Association of Primary Care
Keynote speaker



Pharmacists and GPs need to network in different ways so they can work together in a team, James Kingsland, chairman of the National Association of Primary Care, told delegates.

He said pharmacists becoming partners in GP practices is the future. And if GPs are to take on the less complex work currently done in secondary care, community pharmacies need to be doing near patient testing, he said.

He also added that polyclinics were not necessarily the solution for the majority of the country. "What more can primary care deliver so fewer patients go into hospital?" he asked.

Dr Kingsland criticised some of his GP colleagues over the way they were developing practice-based commissioning. Too many GP consortia are

thinking "can we be another provider?" when considering PBC, he said. Everyone has got to think about things differently, he argued, as doing things the same way will not produce a different result.

In a warning to PCTs, he said that providing new services was not just about undercutting tariffs. "Show me the government policy that says you can start to undercut tariff."

"The whole idea about having a tariff is that we need to start contracting on costs again. So we are seeing PCTs trying to start contracting on costs, trying to ration/topslice, and do the things they did previously that lead us into financial difficulties. And it's a short-term fix."

Karen Acott

C+D Pharmacy Champion,
Pharmacist partner in Wallingbrook Health Centre, Devon

Key message: Just do it – and you'll learn from it.

In a nutshell: Karen Acott believes that England's new pharmacy contract is a landscape which created many open doorways for pharmacists. But although implementing new objectives may be difficult, she believes in using a plan-do-study-act cycle (see www.chemistanddruggist.co.uk for details), adding that "it only takes one patient to try it" to show it can be done. "I think you can start pushing boundaries a lot further and a lot quicker."

Key lesson: Find the niche where outcomes could be improved and where your expertise will benefit patients most. Conducting medicines reviews, Ms Acott says, enables her to 'catch' most of the patients her colleagues don't see and lets her utilise her independent prescriber skills with them. She also conducts chronic disease management clinics.



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C+D Clinical

A burning issue

This article considers the causes, symptoms and OTC management of indigestion

Key points

- 40 per cent of the UK population suffers from indigestion at some point, with 10 per cent thought to suffer on a weekly basis.
- Antacids have traditionally been the mainstay of treatment, as they have a rapid onset of action. However, the effect can wear off rapidly, and there are many drug interactions.
- H₂-antagonists work for much longer than antacids, but have a slower onset of action. They are well tolerated and side effects are rare.
- Proton pump inhibitors have an even longer duration of action than H₂-antagonists and a short course can be effective for many weeks.

Alan Nathan FRPharmS

Indigestion – also known as dyspepsia – is the term used to describe a range of upper GI symptoms, usually associated with the ingestion of food. The clinical features are detailed in table 1 (opposite).

Treatment

Moderately raising stomach pH generally relieves indigestion symptoms. Treatment is therefore aimed at either neutralising gastric acid or suppressing its secretion.

Antacids have traditionally been the main treatment for indigestion. Several alkali metal salts are used; they are weak bases that dissociate to form alkaline salts that neutralise gastric acid. Antacids

Reflect

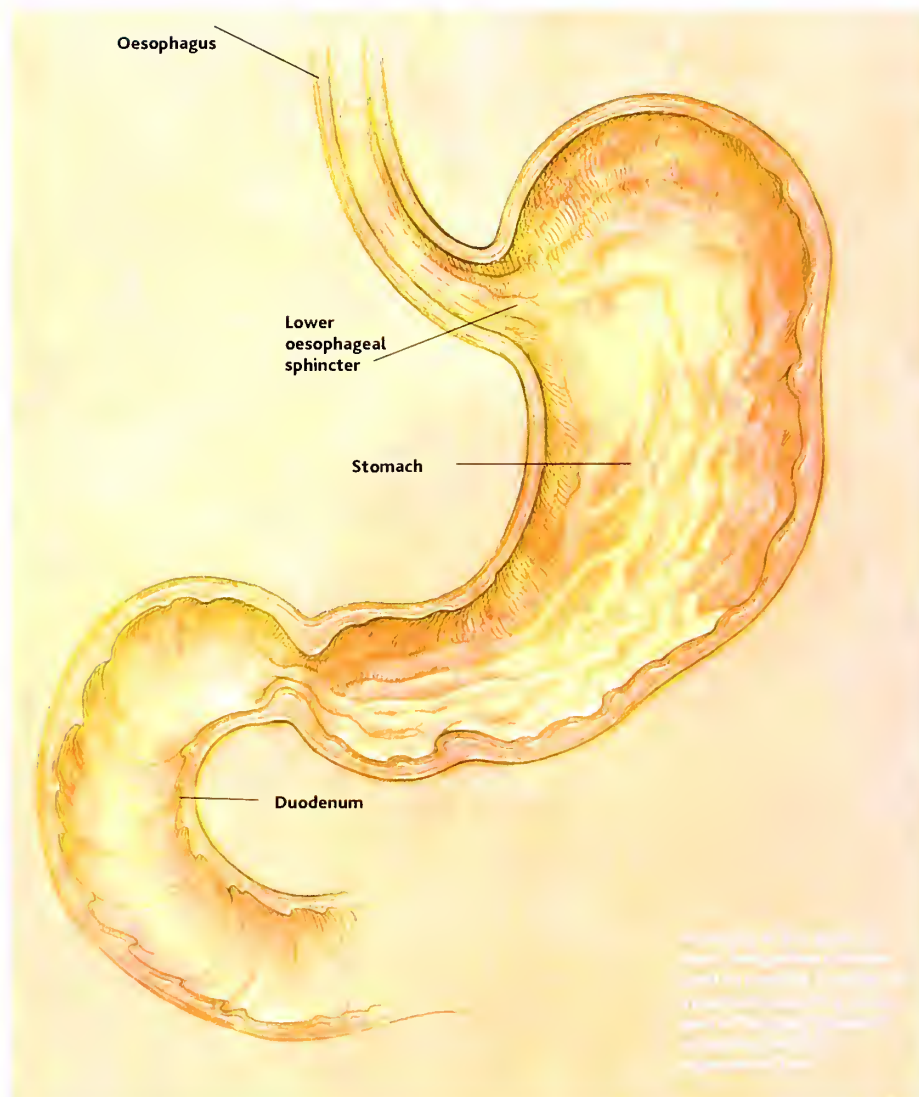
What indigestion symptoms would warrant referral to a GP? What are the main precautions for antacids? What would be the best product for relief of heartburn in pregnancy?

Plan

This article describes the properties and uses of non-prescription remedies for indigestion, including lifestyle hints and when to refer patients to a GP.



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have differing neutralising capacities and the degree to which they are absorbed systemically also varies, influencing their duration of action. Soluble salts act quickly but are absorbed rapidly, so have a short action, while salts of divalent and trivalent metal ions are insoluble and have a less rapid but more prolonged action. Some compounds additionally form a protective layer over the gastric mucosa.

Antacid medicines are often combinations of two or more compounds, intended to optimise speed and length of action and minimise adverse effects. Compounds used are: sodium bicarbonate, potassium bicarbonate, calcium carbonate, aluminium hydroxide, magnesium salts, bismuth salts and magnesium–aluminium complexes.

Antacids interact with many drugs:

- They form insoluble metal ion chelates with tetracyclines, 4-quinolone antibacterials and penicillamine.
- They reduce absorption of tetracyclines and the antifungals ketoconazole and itraconazole, which are less readily soluble in an alkaline than in acid medium.
- They are also likely to reduce absorption of azithromycin, nitrofurantoin, rifampicin,

phenytoin, chloroquine, phenothiazine antipsychotics and bisphosphonates.

- Antacids interact with enteric-coated medicines, which are formulated to resist gastric acid and dissolve – and release the drug – in the more alkaline duodenum. Antacids may cause enteric coatings to disrupt prematurely, causing unwanted release of the drug in the stomach.
- Because antacids can interfere with the absorption of many drugs, patients should be advised to wait at least two hours between taking an antacid and any other medicine.
- Patients on lithium therapy should avoid sodium bicarbonate. Sodium ions are preferentially reabsorbed in the kidney, increasing lithium excretion and reducing plasma lithium concentrations.

Alginates act as reflux suppressants. They precipitate out in the acidic medium of the stomach to form a sponge-like polymer matrix of alginic acid. The reaction between stomach acid and the sodium or potassium bicarbonate in the alginate generates carbon dioxide bubbles, which become trapped in the matrix and make it buoyant so it floats on top of the stomach contents

like a raft. This physical barrier prevents reflux of stomach contents into the oesophagus when peristalsis occurs.

Aluminium and magnesium salts are included in reflux-suppressant formulations to help neutralise stomach contents and any material that is refluxed through the lower oesophageal sphincter (LOS). Gastric alkalisation is also thought to improve sphincter tone. Alginate-antacid preparations appear to be more effective than antacids alone in the treatment of reflux oesophagitis, but less so than H₂-antagonists or proton pump inhibitors, although they act more quickly.

Antiflatulents, carminatives and antispasmodics. Additional constituents are included in some antacids to:

- vent gas trapped in the stomach that contributes to discomfort (antiflatulents)
- act as mild counter-irritants, producing a comforting warm sensation in the stomach (carminatives)
- relieve colicky spasm.

Simeticone is a silicone derivative; its surfactant activity helps to coalesce small gas bubbles into larger ones, which are then vented by eructation. Peppermint and

Table 1. Clinical features of indigestion

Causes	• The term indigestion, also known as non-ulcer dyspepsia (NUD) or functional dyspepsia, describes a range of symptoms in the upper GI tract generally associated with the ingestion of food, for which no underlying pathology can be identified. • There are two types of NUD: –'non-specific' dyspepsia, commonly known as indigestion; and gastro-oesophageal reflux, also known as reflux oesophagitis, gastric reflux or simply reflux, and commonly called heartburn (for causes and symptoms see panel 1 on page 24). • The common causative factor is inflammation of the stomach and/or lower oesophagus caused by hydrochloric acid produced in the stomach.
Epidemiology	• An estimated 40 per cent of the UK population suffer from indigestion at some time. • 10 per cent are thought to suffer on a weekly basis. • There is little difference in incidence between men and women.
Symptoms and signs	Table 2 (page 22) summarises the clinical features of 'non-specific' dyspepsia, gastro-oesophageal reflux disease (GORD) and more serious conditions with symptoms that can be confused with indigestion.
Differential diagnosis and when to refer	Patients should be referred if any of the following are suspected: • Gastric ulcer More common from middle age. Gnawing, constant, annoying pain in mid-epigastrium, starting when stomach is empty. Generally not relieved by antacids or food. Weight loss and GI bleeding. • Duodenal ulcer Incidence and pain as for gastric ulcer. Often wakes patient at night. Relieved by food. • Gastric carcinoma Upper abdominal discomfort with nausea and vomiting, GI bleeding, weight loss, dysphagia. • Atypical angina Similar symptoms to dyspepsia, but with general malaise. May radiate to jaw, neck and arms. Brought on by exertion, cold or a heavy meal. Not relieved by antacids. • Irritable bowel syndrome Symptoms include abdominal bloating and pain in several abdominal areas. The cause is unknown. • Adverse drug reactions Many drugs can cause GI disturbance as a side effect. Those most commonly associated with indigestion include ACE inhibitors, iron, macrolide antibiotics, metronidazole, NSAIDs, oestrogens and theophylline.
Treatment	See main text.
Advice to patients to help prevent indigestion	• Eat regular meals and a balanced diet. • Avoid smoking, excessive alcohol and caffeine, and weight gain. • Try to avoid stress. • Eat small portions of food at regular intervals, without rushing. • Keep fried, fatty and spicy food to a minimum.

Table 2. Clinical features of NUD and some more serious conditions with symptoms that may be misinterpreted as NUD

Feature	Significance	Possible indication
Age	Age under 50 years	NUD likely
	Over 50 and dyspepsia for first time	Consider possible pathological condition
Location	From umbilicus up to sternum	NUD
	Behind sternum	GORD
	Patient can identify specific point in abdominal area	Pathological condition?
Nature of pain	Vague discomfort, aching	NUD
	Burning (heartburn)	GORD
	Gnawing, sharp, stabbing	Pathological condition?
Severity	Mild	NUD
	Severe, debilitating	Pathology
Radiation	Localised to central abdominal region and epigastrium	NUD
	Radiates to jaw, neck, shoulder, arm	Myocardial ischaemia
	Starts centrally and radiates to right iliac fossa after some time	Appendicitis
	Radiates to back and shoulders	Gallstones, peptic ulcer, pancreatitis
Associated symptoms	Bloating, fullness, flatulence	NUD
	Regurgitation of stomach contents; burning sensation and acid taste in throat	GORD
	Persistent vomiting, blood in vomit, black tarry stools	Peptic ulcer, gastric cancer
Aggravated or relieved by	Brought on by food	NUD, gastric ulcer
	Relieved by food	Duodenal ulcer
Personal factors	Stress, eating on the move, excessive alcohol	NUD

other volatile oils have surfactant and counter-irritant properties, but they are also smooth muscle relaxants and may aggravate gastric reflux by relaxing the LOS. Volatile oils and silicones have been shown to be effective in relieving gaseousness, but there is no clear evidence that they are more effective than antacids alone. Dicycloverine and atropine are antimuscarinic drugs included in some indigestion medicines to relieve colic. They relax smooth muscle and inhibit gastric secretion.

H₂-antagonists available without prescription are famotidine and ranitidine. They block the action of histamine by occupying receptor sites on the parietal cells. Histamine is the most important mediator of gastric acid secretion; it

activates receptors on parietal cells, stimulating the enzyme hydrogen/potassium adenosine triphosphatase (H⁺/K⁺ ATPase), causing secretion of hydrogen ions into the stomach. Although H₂-antagonists do not give immediate relief like antacids, their effect is not limited by their length of contact with stomach contents so they have a much longer action. Famotidine inhibits acid secretion and relieves indigestion for about nine hours and ranitidine for about six hours. However, an antacid and H₂-antagonist can be taken together for fast and long-lasting relief.

H₂-antagonists can be taken before consuming food or drink that is known to produce dyspepsia. They are well tolerated and the incidence of side effects is low. However, they should not be sold to

patients taking NSAIDs as they may mask symptoms of developing peptic ulcer, they are not licensed for sale to pregnant or breastfeeding women, and they may reduce the activity of drugs requiring an acid medium for absorption.

There is a large body of clinical research confirming the effectiveness of H₂-antagonists in the treatment of peptic ulcer and related conditions, but little information is available about H₂-antagonists as non-prescription products. Such trials as have been published indicate that they are more effective treatments than antacids for non-ulcer dyspepsia.

Omeprazole is a selective proton pump inhibitor; it directly inhibits the H⁺/K⁺ ATPase of the parietal cells of the stomach ►



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328-0302	VP555	Glucosamine Sulphate	500mg	~~30s~~ 40s	Caps	6	£1.49	£4.18
328-0096	VP579	Glucosamine & Chondroitin	400/100mg	30s	Caps	6	£1.49	£4.18
288-7081	VP020	Glucosamine Sulphate	500mg	~~90s~~ 108s	Tab	6	£3.99	£11.21
288-7099	VP037	Glucosamine & Chondroitin	400/100mg	90s	Tab	6	£3.99	£11.21
328-0278	VP562	Glucosamine Sulphate	500mg	~~90s~~ 108s	Caps	6	£3.99	£11.21
328-0229	VP586	Glucosamine & Chondroitin	400/100mg	90s	Caps	6	£3.99	£11.21

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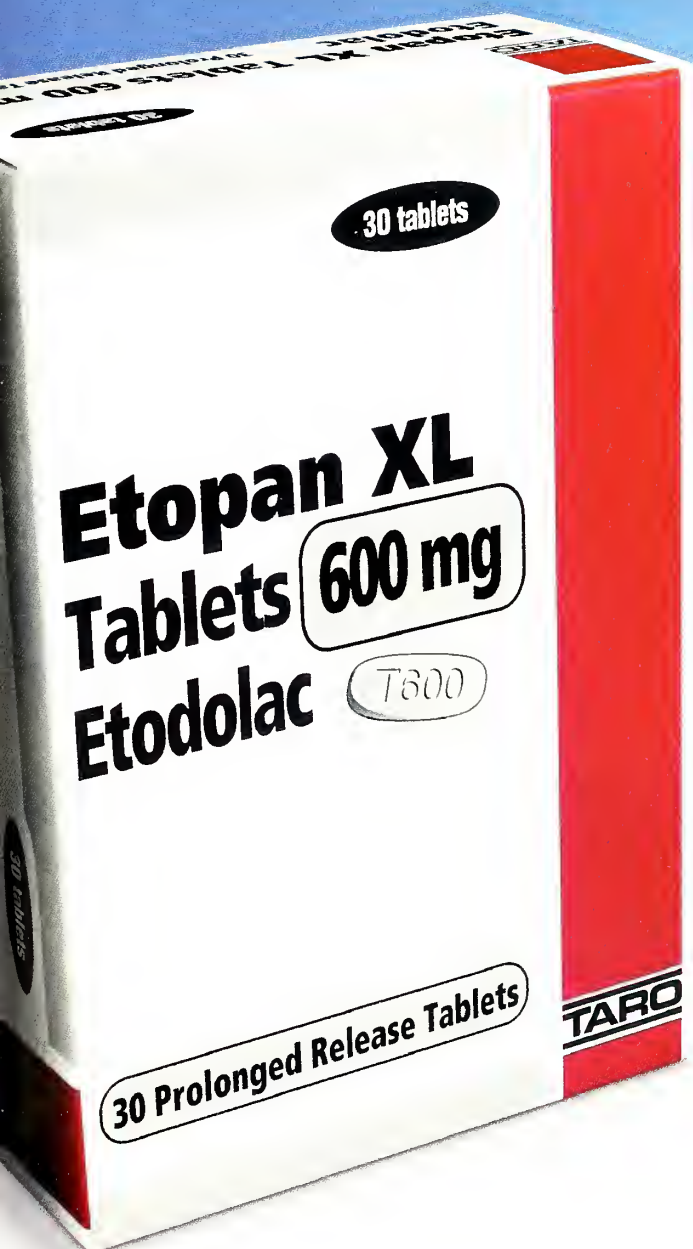


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PRESCRIBING INFORMATION

Presentation: Etopan XL Tablets containing 600mg of etodolac in a film-coated prolonged release formulation. **Indications:** Acute or long-term use in rheumatoid arthritis and osteoarthritis. **Dosage and Administration:** Adults: One 600mg tablet daily. Elderly: No change in dosage is generally required unless renal or hepatic function is impaired. Children: Use in children is not recommended. **Contraindications:** Patients with: existing, or a history of, peptic ulceration/haemorrhage; hypersensitivity to etodolac or any of the excipients; a history of asthma, rhinitis or urticaria during therapy with aspirin or other NSAIDs; severe heart failure. **Special Warnings and Precautions:** Caution is required in patients with: a history of hypertension and/or heart failure; existing or a history of, bronchial asthma; compromised platelet function; a history of GI disease (ulcers, ulcerative colitis, Crohn's disease) as their condition may be exacerbated; rare hereditary problems of galactose intolerance, the Lap lactase deficiency or glucose-galactose malabsorption. Patients with renal, cardiac or hepatic impairment should be monitored in case of deterioration following the use of any NSAID. Patients on long-term treatment should be regularly reviewed for changes in renal or hepatic function or haematological parameters. If any sign of GI bleeding or serious skin reactions, including skin rash, mucosal lesions or

other signs of hypersensitivity occur, treatment should be stopped immediately. The elderly are at an increased risk of side effects, particularly GI effects that can be fatal. Undesirable effects may be minimised by using the minimum effective dose for the shortest possible duration. Etodolac SR Tablets should not be used during pregnancy and its use in nursing mothers should be avoided. **Interactions:** Corticosteroids (increased risk of GI effects). NSAIDs may enhance the effects of anti-coagulants such as warfarin. Concomitant use of ciclosporin, methotrexate, digoxin or lithium with NSAIDs may cause an increase in serum levels of these compounds and associated toxicities. Care should also be taken in patients treated with anti-hypertensives, mifepristone (NSAIDs should not be used for 8-12 days after mifepristone administration), other analgesics including all other NSAIDs, quinolone antibiotics (increased risk of developing convulsions). **Undesirable Effects:** The most commonly observed adverse events are gastrointestinal in nature: Peptic ulcers, perforation or GI bleeding, sometimes fatal. Nausea, vomiting, diarrhoea, flatulence, constipation, dyspepsia, abdominal pain, melena, haematemesis, ulcerative stomatitis, exacerbation of colitis and Crohn's disease. Less frequently, gastritis. Long-term treatment may be associated with arterial thrombotic events. Other side effects include:

Anaphylactoid reactions; serious skin disorders including Stevens-Johnson syndrome and toxic epidermal necrolysis; hepatic function abnormalities and jaundice; oedema, hypertension and cardiac failure; renal problems including renal failure, blood dyscrasias. Prescribers should consult the Summary of Product Characteristics in relation to other side effects. **Legal Category:** POM. **Product Licence Numbers:** 15842/0039. **Date of Preparation of API:** July 2007. **Marketing Authorisation Holder:** Taro Pharmaceuticals (UK) Ltd, Lakeside House, 1 Furzeground Way, Stockley Park East, Uxbridge, UB11 1BD. **Sole Distributors:** Winthrop Pharmaceuticals UK Ltd, One Onslow Street, Guildford, Surrey, GU1 4YS. **For medical information phone:** +44 8707 369544. **For all other information available freephone:** Winthrop 0800 854431.

Information about adverse event reporting can be found on www.yellowcard.gov.uk. Adverse events should also be reported to the Taro UK Office Tel +44 8707 369544/ email: regulatory@taropharma.co.uk

For further information please freephone 0800 854431 or contact Winthrop Pharmaceuticals, 1 Onslow Street, Guildford, Surrey, GU1 4YS. Fax number 01483 554809. Date of preparation: August 2007 STW 336

Panel 1. Gastro-oesophageal reflux disease (GORD): causes and symptoms

- Reflux of acidic stomach contents into the oesophagus is normally prevented by the lower oesophageal sphincter (LOS), which is situated at the junction of the oesophagus and stomach and acts as a non-return valve.
- Several factors can reduce the muscle tone of the LOS, allowing gastric contents back into the oesophagus, including:
 - certain foods and drinks
 - alcohol
 - smoking
 - some drugs
 - obesity
 - pregnancy
 - anatomical abnormality.
- Unlike the stomach lining, the oesophageal mucosa has no protection against gastric acid and an irritant process ensues, giving rise to the characteristic symptoms of reflux oesophagitis – 'heartburn', a burning pain behind the sternum, and 'waterbrash', a sensation of acidic stomach contents regurgitating to the back of the throat.

responsible for gastric acid secretion. It has a more prolonged effect on acid suppression than H_2 -antagonists and a short course can give up to several weeks' remission from recurrent attacks.

Omeprazole is indicated for patients with chronic or intermittent dyspepsia, as long as there is no underlying pathology. Patients should be referred to a doctor if

relief is not obtained after treatment for two weeks.

Domperidone is a dopamine D_2 -receptor antagonist with prokinetic and antiemetic properties. It acts primarily on dopamine receptors in the gastrointestinal tract to enhance gastric and oesophageal sphincter tone, gastric emptying and propulsion of

intestinal contents. It is licensed for OTC treatment of dysmotility symptoms, including sensations of fullness, bloating, 'heavy stomach', trapped wind, belching and nausea.

Alan Nathan FRPharmS is a pharmacy writer and consultant and visiting lecturer at King's College London. Some of the information in this article is based on material in his book, *Non-prescription Medicines* (3rd edition), published by the Pharmaceutical Press.

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Continuing Professional Development



Act

- Read the more detailed descriptions of products used to treat indigestion in C+D's Guide to OTC Medicines and Diagnostics. Make notes of anything you learnt from this exercise.
- Make a list of drugs that should not be taken at the same time as antacids, together with the reason, and have it handy for reference.
- Decide which of the products you stock are most suitable for dealing with the different symptoms of indigestion, eg heartburn, wind, nausea etc. How would you distinguish dysmotility from other types of indigestion? When would you recommend H_2 antagonists or proton pump inhibitors in preference to antacids? Make sure your medicine counter assistants are aware of your treatments of choice.
- Find out which drugs need an acid medium for absorption and whose efficacy might be reduced by H_2 antagonists and proton pump inhibitors.

Evaluate

- Are you confident enough to deal with the variety of indigestion symptoms that patients may present in the pharmacy?

Want to learn more about indigestion?

Find a real-life scenario at

www.chemistanddruggist.co.uk/practicalapproach

Distance learning for pharmacists

Pharmacists using Pharmacy Update for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C+D readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the April 5 issue, which will cover this month's

three CPP-accredited modules. A telephone marking service offers independent verification of results (see the monthly MCQ papers in C+D for details). If you wish to register for Pharmacy Update, please contact Pauline Sanderson on 01732 377269.

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The VIP is a reminder to the patient to take their medicine as prescribed. The VIP is a reminder to the patient to take their medicine as prescribed. The VIP is a reminder to the patient to take their medicine as prescribed.

Vesicare ▼
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ABBREVIATED PRESCRIBING INFORMATION

Prescribing information for Vesicare (solifenacin succinate) tablets. The following information is for the use of Vesicare (solifenacin succinate) tablets in the treatment of overactive bladder. Vesicare (solifenacin succinate) tablets are contraindicated in patients with known hypersensitivity to solifenacin succinate or any of the excipients. Vesicare (solifenacin succinate) tablets are contraindicated in patients with known hypersensitivity to solifenacin succinate or any of the excipients. Vesicare (solifenacin succinate) tablets are contraindicated in patients with known hypersensitivity to solifenacin succinate or any of the excipients.

Contraindications: Known hypersensitivity to solifenacin succinate or any of the excipients. Known hypersensitivity to solifenacin succinate or any of the excipients. Known hypersensitivity to solifenacin succinate or any of the excipients.

Warnings: Vesicare (solifenacin succinate) tablets should be used with caution in patients with known hypersensitivity to solifenacin succinate or any of the excipients. Vesicare (solifenacin succinate) tablets should be used with caution in patients with known hypersensitivity to solifenacin succinate or any of the excipients.



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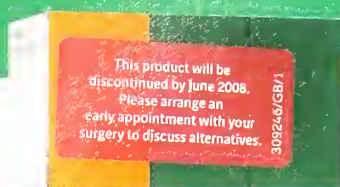
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Combivent® Metered Aerosol (MA) Inhaler is to be DISCONTINUED

(ipratropium bromide and salbutamol sulphate)



Combivent® Metered Aerosol

ipratropium bromide and salbutamol sulphate

Pressurised inhalation, suspension

For oral inhalation only

10 ml vial containing
200 metered doses

Patients are being notified via a sticker on each pack and are advised to visit their surgery for a review

Stickers will appear on UK packs only from January 2008



- Combivent MA inhaler will be discontinued by Boehringer Ingelheim by June 2008.
- Boehringer Ingelheim emphasises that the decision to discontinue Combivent MA inhaler is driven solely by the restriction in use of CFCs, and is in no way based on the safety profile, effectiveness or quality of the product itself.
- This discontinuation affects the Combivent MA inhaler only. Combivent Unit Dose Vials (UDVs®) are not affected and will remain available.
- Posters and patient leaflets are available giving details of the discontinuation. Request these from your Boehringer Ingelheim representative.

If you would like further information on Combivent Metered Aerosol, please contact Medical Information on 0845 602 3809

PRESCRIBING INFORMATION (UK)

Combivent Metered Aerosol (ipratropium bromide and salbutamol sulphate)

Presentation: Metered Aerosol containing a combination of ipratropium bromide (anticholinergic bronchodilator) 20 micrograms and salbutamol sulphate (beta₂-adrenergic agonist) 120 micrograms.

Indication: COPD-associated bronchospasm in patients who require regular treatment with both ipratropium and salbutamol. **Dosage:** Adults (over 12 years): two puffs four times a day. **Contra-indications:** Hypertrophic obstructive cardiomyopathy; tachyarrhythmia; known hypersensitivity to any of the components or to atropine or its derivatives. Hypersensitivity to soya lecithin or related food products such as soya bean and peanut. **Precautions:** Immediate hypersensitivity reactions may occur after administration as demonstrated by rare cases of urticaria, angioedema, rash, bronchospasm and oropharyngeal oedema; concurrent administration with systemically absorbed anticholinergics, xanthines, corticosteroids, other beta-agonists, beta-blockers, monoamine oxidase inhibitors, tricyclic antidepressants, halogenated hydrocarbon anaesthetics; not to be used in pregnancy or lactation unless the benefits outweigh the possible hazards to the child. Instruct in correct use and warn not to allow contact with eyes as there have been rare reports of ocular complications (i.e. mydriasis, blurring

of vision, narrow-angle glaucoma, eye pain). Patients who may be pre-disposed to glaucoma should be specifically warned to protect their eyes. If eye pain/discomfort, blurred vision, visual halos or coloured images, with red eyes from conjunctival congestion or corneal oedema develop (suggesting acute narrow-angle glaucoma), treat with miotic drops and seek specialist advice immediately. Advise patient to seek medical advice in the event of acute, rapidly worsening dyspnoea or if response lessens. Use with caution in patients with; recent myocardial infarction and/or severe organic heart or vascular disorders; insufficiently controlled diabetes mellitus, hyperthyroidism, prostatic hypertrophy, pheochromocytoma, and risk of narrow-angle glaucoma. Potentially serious hypokalaemia may result from beta₂-agonist therapy, particularly in severe airways obstruction, xanthine derivatives, steroids, and diuretics may potentiate this effect. Additionally, hypoxia may aggravate effects of hypokalaemia on cardiac rhythm, especially in patients receiving digoxin. It is recommended that serum potassium levels are monitored in such situations. Patients with cystic fibrosis may be more prone to gastro-intestinal motility disturbances. **Side-effects:** In common with other beta-agonists more frequent undesirable effects are fine tremor of skeletal muscles and nervousness, less frequent are tachycardia, dizziness, palpitations or headache, especially in hypersensitive patients. Potentially serious hypokalaemia may result

from beta₂-agonist therapy. In isolated cases there may be local reactions such as dryness of the mouth, throat irritation, dysphonia or allergic reactions. As with other bronchodilators, in some cases cough, in very rare instances paradoxical bronchoconstrictions have been observed. As with other beta-mimetics, nausea, vomiting, sweating, weakness and myalgia/muscle cramps may occur. Allergic-type reactions such as skin rash, pruritus, angioedema of the tongue, lips and face, urticaria (including giant urticaria), laryngospasm and anaphylactic reactions have been reported. As with all beta₂-agonists hyperactivity in children is possible. Prescribers should consult the summary of product characteristics in relation to other undesirable effects. **Pack Size and Basic NHS price:** 10ml vial complete with mouthpiece containing 200 doses £6.77 PL 00015/0191. **Legal category:** POM. **Product Licence Holder:** Boehringer Ingelheim Limited, Ellesfield Avenue, Bracknell, RG12 8YS. For full prescribing information please see summary of product characteristics. Updated August 2007

Adverse events should be reported to Boehringer Ingelheim Drug Safety on 0800 328 1627 (freephone). Information about adverse event reporting can be found at www.yellowcard.gov.uk

A Practical Approach

Antidepressants for arthritis?



Bethany Straker

Bernice Wachsman goes into Update Pharmacy and asks to speak to the pharmacist. When he comes out, she says, "Mr Spencer, I think Dr Hyder's lost it."

"Why do you say that?" asks David.

"You know Dr Hyder, he's a bit of an oddball, but I've always found him to be an excellent GP. But I think he's got it totally wrong this time. You know that I've had a touch of arthritis for a few years? Well, I

went to see him because it's been getting much worse lately – I've been getting pains all over my body, in my muscles as well as my joints.

"The nights are awful because I keep waking up with aches, especially in my lower back and legs, and because of the poor sleeping I've been tired all the time.

"So I went to Dr Hyder, he checked me over then told me to carry on with my usual painkillers, join a gentle aerobics class and take some new tablets. But he's given me amitriptyline, which my sister-in-law used to take for depression. I know I'm a bit low at the moment because of this problem, but I wouldn't say I'm depressed."

David thinks for a moment, then replies: "I think Dr Hyder knows what he's doing. You should give them a try, Mrs Wachsman."

Questions

1. Assuming that Dr Hyder is right, what condition might Mrs Wachsman be suffering with?
2. What are main diagnostic features?
3. What is the role of antidepressants in this condition?
4. Why did Dr Hyder recommend aerobic classes?



This article can help in the following CPD competencies: **G1a, G1d, G1e, G1s, G2k, C1a**. See www.tinyurl.com/194zu

Answers

1. Fibromyalgia, a condition of unknown aetiology affecting mainly women between 25 and 50 years of age.
2. Widespread pain; pain on pressing a number of specific 'tender points' around the body; morning stiffness; unrefreshing sleep; fatigue.
3. Fibromyalgia sufferers have been found to have lower than normal levels of serotonin. There is some evidence that amitriptyline at night improves quality of sleep and reduces pain and morning stiffness. However, fibromyalgia patients appear to be particularly sensitive to amitriptyline's sedative and muscarinic side effects, so doses should be titrated to the lowest effective. SSRIs are also used to treat fibromyalgia.
4. There is evidence that exercise can significantly improve the symptoms of fibromyalgia for most people. Low impact aerobic exercises – such as walking, cycling or swimming – are thought to be best.

References

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Gowans SE, deHueck A, Voss S, et al. Six-month and one-year follow-up of 23 weeks of aerobic exercise for individuals with fibromyalgia. *Arthritis Rheum* 2004; 51:890-898.

For more information read the Pharmacy Update article on fibromyalgia, available at www.chemistanddruggist.co.uk/update

Clinical Alerts

SPC Changes

Losec range (omeprazole) Warnings on use with vitamin K antagonists and voriconazole, and dermatitis added to undesirable effects section.

Acezide tablets (captopril, hydrochlorothiazide) Alpha-blockers and carbamazepine added to interactions.

Zocor tablets (simvastatin) Fusidic acid added to interactions section.

Viramune range (nevirapine) SPC extensively revised.

Inovelon tablets (rufinamide) Warning added on use in patients with congenital short QT syndrome, or a family history of the condition.

Aldurazyme infusion (laronidase) Warning added on risk of infusion-associated reactions in patients with an acute underlying illness at the time of treatment.

www.emc.medicines.org.uk

Doubt thrown on SSRI link to suicide rates

SSRI prescribing and suicide rates in adolescents do not appear to be linked, according to two papers published online by the BMJ.

The first of the papers analysed the suicide rate since the UK prescribing of selective serotonin reuptake inhibitors (SSRIs) for adolescents was restricted five years ago amid fears the drugs caused suicidal side effects.

Studies in other countries have suggested limiting use of SSRIs leads to increased untreated depression and an accompanying increase in suicide levels, but this does not appear to have happened in the UK.

The second paper, a time trend analysis, found that suicide rates in young men declined steadily throughout the 1990s,

reaching their lowest level for nearly 30 years in 2005. SSRI prescribing increased rapidly from the early 1990s, but the rise did not correspond to the decline in suicides.

A BMJ editorial accompanying the two online papers states: "In truth, it would be surprising if antidepressants had any effect – positive or negative – on the risk of suicide in the general population." Dr Gregory Simon, an investigator at Seattle's Centre for Health Studies in the US, explains: "Sustained use of antidepressants is probably too rare to have much overall effect on risk of suicide in people living with depression."

www.bmj.com/channels/research.dtl

Clinical Alerts

SPC Changes

Fludara tablets (fludarabine phosphate) Statement added that drug is not recommended for use in children.

Deltacortril enteric-coated tablets (prednisolone) Potentially severe psychiatric adverse reactions added to side effects and warnings sections.

Vfend range (voriconazole) Warnings added on concurrent use with alfentanil and efavirenz.

Sebivo tablets (telbivudine) Warning on risk of peripheral neuropathy developing, particularly in patients on telbivudine and pegylated interferon.

New Products

Xeomin injection (clostridium botulinum toxin type A) Indicated for the symptomatic management of blepharospasm and spasmodic torticollis in adults. Merz Pharma, tel: 0845 009 2440.

Tazocin injection (piperacillin, tazobactam) Reformulated to meet European Pharmacopoeia standards. Wyeth Pharmaceuticals, tel: 01628 604377.

Cetraben cream 1,050g (white soft paraffin, liquid paraffin) New pack size introduced, available from March 3. Genus Pharmaceuticals, tel: 01635 568400.

Clinical News

CKS updated

The DH's Clinical Knowledge Summaries now include management summaries covering iron deficiency, childhood immunisations, venous leg ulcers, opioid dependence and constipation in palliative care.

<http://cks.library.nhs.uk>

Anxiety over CV risk calculator

A lipid specialist has expressed concerns shared by many of his colleagues about the haste with which Nice is adopting a new tool for calculating cardiovascular risk.

Nice is advocating the new QRISK calculator in place of the established Framingham calculator.

A Heart UK spokesman and medical, scientific and research committee member told C+D that his organisation was very much in favour of the aims of the new risk calculator.

Because the Framingham calculator is based on decades-old US data taken from predominantly prosperous white men, it has weaknesses in a number of areas.

However, QRISK is based on a much larger UK general practice population, and takes issues such as racial makeup, family history and socioeconomic status into account.

But the spokesman said many doctors were concerned that the inner workings of QRISK had not been open to wider access and scrutiny.

"It's a bit like a black box to clinicians at the moment," he said. "We don't fully understand how the weightings of the various risk factors work, and some – such as obesity and socioeconomic status – are not fully independent."

"A particular concern was that there were no figures for total/HDL-cholesterol ratio for many of the patients included in the database, which was developed for a different purpose."

"We're surprised at the Nice decision to go for such early full scale adoption," he added.

"Perhaps it could have been introduced in parallel to allow for a fuller evaluation in everyday clinical practice."

Combined therapy effective in Crohn's

Patients with newly diagnosed Crohn's disease benefit more from combined immunosuppressants than from conventional corticosteroid treatment, a trial published by The Lancet has concluded.

Treatment protocols may have to be changed if the result is confirmed in a forthcoming US trial, a commentator has suggested.

The two-year open-label trial compared 133 patients at 18 European centres.

One group received three infusions of infliximab a week as well as azathioprine, and additional infliximab or corticosteroids if necessary. A second group received corticosteroids followed by azathioprine

and infliximab as required.

By week 26, 60 per cent of patients in the infliximab with azathioprine group were in remission without corticosteroids or surgical resection, compared with 35.9 in the conventional corticosteroid treatment group.

Similar numbers of serious adverse events were seen in both groups.

In an accompanying comment article, Mayo Clinic inflammatory bowel disease expert Dr William Sandborn said that treatment protocols could change if a US trial due to report in the latter half of 2008 confirmed the European result.

Lancet, 2008; 371: 660-7.
www.thelancet.com



Finding up-to-date information about migraine drugs needn't give you a headache

Try SearchMedica - the new search engine for pharmacists

Developed in consultation with practising pharmacists and C+D, SearchMedica is a unique search engine that gives you access to the medical information you need.

Whether you are looking for information on regulation, side-effects or drug alerts, SearchMedica's multiple search options and categorised results will help you find it online.

Try it today - www.searchmedica.co.uk



Avian flu vaccine gets go-ahead

The first pre-pandemic vaccine available for avian flu has been given the green light by the European Medicines Agency (EMA).

Prepandrix is a vaccine prepared from influenza viruses that have the potential to cause a pandemic. The GSK Biologics product would be used either before or during a declared pandemic to trigger an immune response against the H5N1 strain of the influenza virus.

Other positive opinions granted by EMA's committee for medicinal products for human use included:

- Adenuric (febuxostat) for the management of chronic hyperuricaemia.
- Mycamine (micafungin sodium), an intravenous anticandidal agent.
- Privigen (human normal immunoglobulin) for replacement therapy in immunodeficiency, and immunomodulation.
- Volibris (ambrisentan) for pulmonary arterial hypertension.

Furthermore, the committee approved licence extensions for the following products:

- Abilify (aripiprazole) for moderate to severe mania in bipolar disorder, and to

prevent manic episodes.

- Alimta (pemetrexed) as first-line treatment with cisplatin for locally advanced or metastatic non-small cell lung cancer.
- Forsteo (teriparatide) for steroid-induced osteoporosis.
- Neoclarityn (desloratadine) for urticaria.
- Coxtral (nimesulide), a pain relief gel, and Eformax (formoterol fumarate) for asthma control did not fare so well, with EMA saying that the benefit-risk profile for both was unfavourable.

www.emea.europa.eu

One child in three is overweight

One child in three in school year six is now officially overweight or obese, according to the latest government survey figures.

The results of the National Child Measurement Programme, covering 80 per cent of children in reception and year six, also show that one child in four was overweight in the reception year.

Boys were more likely to be obese than girls, and children in London more likely to be obese than anywhere else in the UK.

Obesity Forum clinical director Dr David Haslam said the number of overweight children observed in year six was surprisingly high, and cautioned that the 20 per cent of children yet to be surveyed could turn out to be heavier still.

He added that the survey showed how much adult perceptions had changed, for few people would be immediately aware that so many children were overweight.

"Parents will have very little motivation

because they will not be aware that their children are overweight. The Obesity Forum would like to see pharmacy playing more of a role, offering lifestyle advice focusing on physical activity and nutrition on every possible occasion," he said.

- The British Heart Foundation said young children were particularly susceptible to advertising, and called on the government to ban all junk food marketing to children.

<http://tinyurl.com/25mack>

CRISIS

MANAGEMENT



Chlorhexidine digluconate

Treats gum disease



Maintains healthy gums



GlaxoSmithKline
Consumer Healthcare

Corsodyl Mint Mouthwash is indicated for the treatment of gingivitis. Further information is available from GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, UK. 

With low strength chlorhexidine digluconate
and fluoride it's quite a mouthful

08

AWARDS



How to enter

- ◆ Choose which category(ies) you wish to enter and complete the entry form opposite. There is no limit to the number of categories you can enter, but you must submit a form for each entry and it should be clearly marked with the category entered. Guidelines on the categories can be seen at www.chemistanddruggist.co.uk/awards.
- ◆ In no more than 1,000 words, state what you have done and why you did it, referring to the guidelines at www.chemistanddruggist.co.uk/awards for the particular category that you have entered. You must explain how you achieved your goal, and the outcomes. The judges will mark the entries against three criteria: innovation; maximising resources and skills; and sustainability, and you must say how you addressed these criteria in your submission. You will also be judged according to whether you have understood and fulfilled the entry requirements as stated in the category guidelines. Supporting material (clearly marked and ordered) such as testimonials, photographs, service protocols, press clippings, marketing material, etc should be included to enhance your chances of winning. Entries must be typed and accompanied by the entry form opposite.
- ◆ Send **FOUR COPIES** of your entry form and supporting material to Katherine Mannix, Group Events Manager, C+D Awards 2008, Ludgate House, 245 Blackfriars Road, London, SE1 9UY. Alternatively you can email your entry with supporting materials to entries@chemistanddruggist.co.uk (3MB max limit) by **5pm on Friday 14 March 2008**. All entry forms and supporting material should be sent together.
- ◆ All entries will be treated in the strictest confidence and will only be used for the purpose of this judging process. We are unable to return entries and supporting material, so you may wish to send copies rather than the original documentation.
- ◆ The judges will independently mark each entry against specific award criteria. The judges' scores will then be collated to find the winner.
- ◆ The winners will be revealed and presented with their trophies at the awards ceremony on Wednesday 18 June 2008 at the Grosvenor House Hotel in London. The winners will also be featured in C+D following the awards evening.

The award categories

1. Community Pharmacist of the Year - sponsored by Teva UK
2. Pre-registration Graduate of the Year - sponsored by Reckitt Benckiser Healthcare
3. New Pharmacist of the Year - sponsored by Teva UK
4. Pharmacy Manager of the Year
5. Technician of the Year - sponsored by Actavis
6. Pharmacy Assistant of the Year
7. MUR Champion of the Year - sponsored by Pfizer
8. Clinical Service of the Year
9. Retail Service of the Year - sponsored by T&R Care
10. Business Development of the Year - sponsored by GlaxoSmithKline
11. Green Award
12. Pharmacy Team of the Year - sponsored by McNeil

Full category details can be found at www.chemistanddruggist.co.uk/awards

Don't forget, all entries go into a prize draw to win a holiday of a lifetime worth

£3,500

If you have any queries regarding this form or any aspect of the C+D Awards 2008 please contact Katherine Mannix on 0207 234 8729 or email kmannix@cmpi.biz

Hint and tips

- ◆ Ensure you provide all the requested information, and stick to the stated word count
- ◆ Keep the message clear. Bullet points, sub-headings and short punchy sentences will make it easier to present your case
- ◆ Use hard data to substantiate your claims wherever possible
- ◆ Use pictures wherever possible to catch the judges' eye
- ◆ Testimonials from service users will help considerably in selling your entry to the judges
- ◆ Don't be afraid to sell yourself – make sure your passion comes through
- ◆ Run your entry by a colleague

When compiling your entry, you may - where applicable - wish to consider areas such as:

- ◆ How was the idea researched?
- ◆ How did the service integrate pharmacy into patient care networks – did you partner with other professionals/agencies?
- ◆ How did the service utilise staff and what training was required?
- ◆ How was IT employed?
- ◆ How was the service marketed and service users recruited?
- ◆ How was the service funded on launch and in the future?
- ◆ How does the service promote pharmacy?
- ◆ How successful was the service?
- ◆ How long has the service been running and how has it grown?
- ◆ How successfully has the service been adopted by others?
- ◆ How does it fit in with local and national targets?

Entry form

Further forms can be downloaded at www.chemistanddruggist.co.uk/awards

Part 1 – your details (please complete all fields and send this form or a copy with your entry submission to: Katherine Mannix, Group Events Manager, C+D Awards 2008, Ludgate House, 245 Blackfriars Road, London, SE1 9UY)

Category entered

Your full name

Job title

Name of pharmacy

Address

Postcode

Telephone no

Mobile no

Email

CMP Medica will only use your details to contact you for the purpose of your entry into the C+D Awards, and your details will not be passed to third parties



Closing date 14 March 2008

The holiday prize is sourced and provided solely by Chemist+Druggist magazine

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Consumer Healthcare



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Winning an award is your ticket to transforming business for the better.

Max Gosney reports

The glitzy award ceremony – a night of red carpets, Dom Perignon and tearful acceptance speeches. What was once the reserve of Hollywood stars and teenage pop queens is now open to a wider audience. C+D will host its very own pharmacy Oscars this summer and the rewards for the victors could extend well beyond the winners' gong.

Many people can't be bothered with awards. No point faffing around with the entry forms, they say. There's no chance of winning and anyway we're too busy dealing with the morning rush from the surgery to even try. Shame on you, says Raj Patel of Mount Elgon Pharmacy in Wimbledon. "If you don't enter awards then you can carry on muddling around doing the same old thing. Awards make you channel your energy in a positive way. They're a vehicle to being the best."

Five reasons to enter awards

1. Winning a gong is a pat on the back for you and your staff and can be a massive motivational aid.
2. An award is a positive sign of a pharmacy's capability to provide services, according to PCTs.
3. Customers see an award as a seal of quality and could spread the word on your success.
4. It's great PR: tell the local newspapers.
5. Success breeds success: if you can land one award then it will bolster your chances of a second, particularly if you perfect the entry form. Also, the award can help retain and recruit staff.

Mr Patel has been the toast of the town since being crowned overall winner at the UniChem awards last autumn, he reveals. "Local customers love it. We've had the pictures of me winning the prize in the window display and the whole community recognises the fact we're a good pharmacy." The message filters up to the top, he adds. "When the patients go to the GP they say things like: 'Did you know Raj won this award?'. It also built my reputation with the PCT and they're pushing me to do supplementary and independent prescriber courses."

There's nothing like winning an award to get tongues wagging it seems. Lila Thackerar sent the neighbourhood gossips into overdrive when she was named overall winner of the UniChem Great Business Awards in 2005. "Word gets around," she explains. "It's a bit like an EastEnders scenario: everyone is talking about it. I think it's the best thing that can happen to any business. It's built the community's confidence in us and you can't put a figure on that."

Sure, filling out entry forms can be tedious, reflects Ms Thackerar. But there are shortcuts, she says. "I have my own presentation on file and can tailor this to each award I enter." Perfecting your entry form now will pay off further down the line, she adds. "People see the forms and think 'I can't be bothered'. But for every pharmacy' no matter how big or small, there's an opportunity to be recognised. That professional recognition is incredibly satisfying."

It's also very alluring to the public, says marketing expert Mike Lewis. "Awards provide an independent stamp of approval and that quality assurance is something customers

Winner



takes all



are looking for." And should you pick up a prize then make sure you make a song and dance about it, says the director of marketing firm Clarity in Marketing. Celebrating your success with a party is a terrific publicity ploy, he advises. Take note of sports teams who parade trophies around the town in open top buses and cash in on some glory by inviting your local patients and PCT to help you celebrate.

You may even find the experience helps the PCT enter the party spirit the next time it is looking to roll out services, says Stephen Woods, prescribing development manager at Salford PCT. "If you had to choose between two pharmacies and one had won an award for providing services then you would go with that one." Although possessing a prize isn't the only factor in winning over PCT bosses, it certainly can't harm your chances, Mr Woods adds.

But, the real benefit of winning an award stretches beyond

How to maximise success

- **Show off the trophy in the shop window.**
- **Email the newspapers, TV and radio stations.**
- **Supply the local GP with a leaflet about your success and ask him to distribute it at the surgery.**
- **Invite the local PCT and patients to toast your success with a party. Invite the local press and your MP.**
- **Print your award on your prescription bags or add it to till receipts. This will help spread the word about your success to customers and beyond.**

Tips courtesy of marketing expert Mike Lewis

boosting your reputation with the PCT or impressing customers. Barry Shooter, of Aldeburgh Pharmacy in Suffolk, former owner of a pharmacy chain named fourth in the Sunday Times list of Small & Medium Best Companies to Work For in 2004, explains: "I think the awards are as much about the staff being proud of their achievement as wowing customers. Winning the award really motivated the staff."

The performance-enhancing effect is as relevant to employees as it is to stand-alone contractors, says Rowlands managing director Kenny Black. "We run internal awards. It's a recognition of the staff and gives them a real boost," he says.

Gordon Farquhar, the Co-op Pharmacy's commercial director, adds: "For those at the top of their game, and who are innovative and pushing boundaries in the work they do, it is important to gain recognition from their peers."

However, before you put your trophy on public display be aware of a few pitfalls, advises Roy Jones of the Chartered Institute of Marketing. "If you've won a customer services award and the service that day is poor, the award will become a stick to beat you with." Also, clinging on to past prizes is a definite faux pas, he adds. "There's nothing worse than seeing a business displaying an award from 1999; you wonder what they've been doing since."

But, if you can avoid the hazards then receiving an accolade is about the most powerful motivational tool a business can get, Mr Jones concludes. So whether you are working for a high street giant or run a small rural pharmacy, everybody loves a winner. Fill in the C+D Award entry form. More details on pages 32, 33 and inside back cover.

Bonjela's quick fix



Bonjela Once has been launched by Reckitt Benckiser. As its name suggests, one application stops the pain of mouth ulcers, says RB.

The product is derived from hybenx technology and contains a combination of ingredients to find and remove damaged tissue, says the company. It is presented as a cotton bud, first used to dry the ulcer then snapped to release the treatment at the other end. A protective seal is formed, covering the nerve endings to relieve pain and prevent contamination.

RB expects the launch to bring new users to the category who don't currently treat as they feel there is not a product meeting their needs.

The Bonjela brand will be supported with £2.1 million worth of promotional support to include TV, online and press advertising. Training and point of sale materials are available.

Price: £8.99/two applications
Pip code: 334-2516
Reckitt Benckiser
Tel: 01482 326151

Sanex range matures

Dermo re-vital is a new range from the Sanex skincare brand. It is designed to provide more mature skin with the care it needs to stay healthy, says manufacturer Sara Lee.

Positioned for the 35+ market, the range includes bath, shower and handwash variants enriched with omega-6 and AHA for nourishment and protection of the skin. The deodorant, in aerosol and roll-on formats, contains zinc and magnesium to help keep underarm skin healthy, says the company.

Support for the launch includes

Price: from £1.59 to £2.99
Pip code: see C+D Monthly Pricelist
Sara Lee Household & Body Care
Tel: 01753 523971



TV advertising to the tune of £1.2 million running throughout March. Aiming for a 35 to 54-year-old,

ABC1 demographic, the 10 and 20-second ads are expected to reach 78 per cent of the target audience.

New name, more energy

Ensure Plus Juice is the new name for Enlive Plus from Abbott Nutrition. The move aims to simplify prescribing, bringing all products within the Ensure Plus family, says the company.

The product is said to contain more energy and protein than comparable nutritional drinks and is available in six flavours.

Product info:
Abbott Nutrition
Tel: 0800 252 882
www.abbottnutritionuk.com

Cetraben goes large

A 1,050g pack size of Cetraben is newly available from Genus Pharmaceuticals. The GSL product with a pump dispenser becomes available on the NHS from March 3.

Price: £11.11
Pip code: 327-0550
Genus Pharmaceuticals
Tel: 01635 568400



Hold on to your hair

Haircare brand Schwarzkopf is entering the hair loss sector with its latest launch: the Activ hair retention care system. Comprising a shampoo and tonic designed to encourage hair growth and reduce normal hair loss, there are gender-specific variants: Activ F for women and Activ M for men.

The range is expected to appeal to the 35 plus, ABC1 demographic and launched initially in Boots in

mid-February. It rolls out to independents this month, supported by extensive marketing.

The products should be used for at least three months to see results, with ongoing use recommended, says Schwarzkopf.

Price: shampoo £9.99; tonic £12.99
Schwarzkopf & Henkel
Tel: 01296 314000



Products advertised on TV next week

Abidec: All areas except five
Anadin Extra & Ultra: All areas
Buscopan: GMTV
Covonia: GMTV, Sat, five,
Cura-Heat: All areas, except GMTV
DulcoEase: GMTV, Sat, five, LWT, CAR
Lyclear SprayAway & Repellant: GMTV, Sat
NiQuitin: All areas
Seven Seas JointCare & CLO: All areas
Vagisil Creme: All areas
PharmaSite for next week: Ibuleve – windows, Ibuleve – in-store, Ibuleve – dispensary
Pharmacy channel: NiQuitin, Fusion Condoms, Clearly Herbal

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Abbott's gotta lotta bottle



Ensure Plus products are moving over to a bottle format. Replacing the existing Tetrapak, the bottle is designed to be easier to use and was created following market research among patients and healthcare professionals.

It features a large ribbed lid, helpful for patients with reduced muscle strength or impaired manual dexterity. A sticker on the lid allows patient details to be

added, while the shape of the bottle is easy to hold.

The transition to bottles will be phased in gradually, with all styles and flavours to be in bottles by the end of the year.

Product info:
Abbott Nutrition
Tel: 0800 252 882
www.abbottnutritionuk.com

Tins to the Rescue

Rescue Remedy pastilles have been added to the stress-fighting flower essence range from Nelsons.

Flavoured with elderflower and orange, the pastilles are free from alcohol or sugar and suitable for all the family.

They are presented in a click-shut tin described by Nelsons as "handbag friendly" and ideal for travel.

The new product is predicted to give the range greater stand out on shelf while giving consumers greater choice.



Price: £4.95/50g
Pip code: 325-1188
Nelsons
Tel: 0800 289 515
www.rescuerecure.co.uk

Cooling reminder

Refrigeration specialist Labcold is reminding pharmacists their fridges must comply with the new Department of Health Green Book requirements on vaccine refrigeration and RPSGB guidelines.

New to the Labcold range of pharmacy refrigerators are the

glass door 285 and 150 litre models, joining the existing solid door range.

Product info:
Labcold
Tel: 0870 3001001

NEW

a major breakthrough for minor burns



New Acriflex Cooling Burns

Gel uses OSMO4 osmotic technology which has been clinically proven to soothe by rapidly cooling the skin tissues to relieve discomfort, reduce the redness of inflamed skin, hydrate the surface layers of the skin to promote its natural repair system and kill bacteria through physical action without drying the skin.

Find out more from your T&R representative, or call 01484 842217.



CE
CE0459

✓ cools ✓ reduces inflammation ✓ hydrates ✓ promotes repair

Presentation: Glycerin, PEG-8, caprylyl glycol, sodium polyacrylate, carbomer, sodium hydroxide and purified water. Indications: for application to superficial burns such as may occur in the home; sun-burn and minor skin irritations. Dosage and Administration: For adults and children over 2 years of age apply to unbroken skin and massage gently. Leave for a few minutes to penetrate. Repeat 2-3 times daily. Contraindications: Sensitivity to the product or any of its ingredients. Warnings: Avoid contact with the eyes. Do not use after the expiry date. Store at room temperature. Keep away from sources of heat. Keep out of the reach of children. Legal Status: Class IIA medical device. Pack Size: 30g RSP excl VAT: £3.29. Date of preparation: January 2008. Further information is available from Thornton & Ross Ltd, Linthwaite, Huddersfield HD7 5QH.


0207 921 8119

Booking and copy date
12 noon Monday prior
to Saturday publication subject
to availability

Contact:

Simon Pittman
Chemist + Druggist (Classified),
CMP Information Ltd
Ludgate House
245 Blackfriars Road
London SE1 9UY

T: 0207 921 8333
F: 0207 921 8130

www.chemistanddruggist.co.uk
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Organised and self-motivated individuals to assist in the provision of pharmacy services to Care Homes and home based patients referred by hospitals.

No previous experience in this sector is necessary as full training will be provided.

This is a unique opportunity to work in the growing areas of Home Care Dispensing Services.

Please your CV and cover letter to info@intecareuk.com

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Pharmacy Technician - London

London SE18 based Pharmacy seeks to appoint a Pharmacy Technician. Duties and responsibilities to include advice on pharmaceutical products, supplies, dispense prescriptions, dossett packing for care homes, control stock, ensure effective service to customers, supervision of support staff, preparation of products. Must be able to work independently, and be willing to work long hours and weekends also undertake home deliveries.

Must have relevant skills acquired through three years working experience in this field at NVQ level three or above. Salary £18-20k

Applications to:- St James medichem Ltd
pharmacyadmin@googlemail.com

Closing date for applications: 1st April 2008

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**Box 108, Chemist and Druggist, CMP Medica,
Ludgate House, 245 Blackfriars Road,
London, SE1 9UY**
enclosing an introductory letter and
a copy of your CV.

Buying Assistant

**JOB VACANCY
BUYING ASSISTANT**

Reporting to the pharmacy Ethical Buyer, a vacancy has arisen for a Buying Assistant within the Professional Services Department at Numark.

The main duties of the successful candidate will be as follows;

- To assist in the development of commercial programmes which help Numark members to maximise their NHS profitability
- To assist in identifying areas of opportunity for suppliers to invest in the development of services for Numark members
- To be solely responsible for the management of a number of supplier accounts
- To analyse and produce reports on market performance which will assist in decision making
- To assist in the marketing of new programmes to its stakeholders to encourage the highest levels of participation
- To undertake any other duties necessary at the request of the department to ensure the operational effectiveness of the department

Applicants will have excellent interpersonal, communication and organisational skills and should be able to work effectively both alone and as part of a team. A high level of enthusiasm and energy is required as well as attention to detail and to be able to use their initiative. A good working knowledge of Excel spreadsheets and knowledge of Microsoft Access would be advantageous.

This is a full time position working 37.5 hours per week based in Tamworth. If you feel you have the necessary skills and are interested in this position, please submit your CV and covering letter to:

Sundeep Nagra
Pharmacy Ethical Buyer
Numark Ltd

5/6 Fairway Court, Amber Close, Tamworth, Staffordshire B77 4RP
Closing date for applications: Friday 14th March 2008

Cosmetic / Pharmacy Manager

**COSMETIC/PHARMACY MANAGER
LONDON**

We are currently looking for an experienced Pharmacy Assistant with cosmetic/dispensary and managerial experience for our branch in Victoria, London SW1.

Please apply with CV to :

**The Superintendent Pharmacist
Warwick Pharmacy
34-36 Warwick Way, London, SW1V 1RY**

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Roger Button on 07887 777974

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Please contact Mohamed on 07958 428754 or
Talha Patel on 07841 328394

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Please contact Denis O'Leary in confidence on

01206 323808 or mobile 07920 476222

email denis.oleary@pharmacybusinesstransfer.co.uk

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Dorset	T/O C:	£730,000
N. London	T/O C:	£500,000

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From: **Hawkeye on the web**
 Date: **Sat 1.3.08**
 Subject: **Doctor Google**



Up to **10,000**
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 participate in a
 pilot of
Google Health

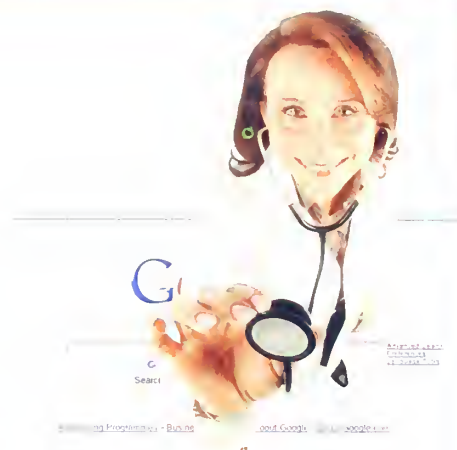
Who would you trust with your patients' personal medical details? With numerous high profile security malfunctions over the past year, you would be forgiven for being a little nervous about the government's track record when it comes to data protection (www.tinyurl.com/28h9bo).

GPs made their feelings on the subject clear earlier this month in a BMA survey which found that 93 per cent of doctors did not have faith in the government's ability to secure medical records via the centralised data 'spine' at the core of the Connecting for Health programme (www.tinyurl.com/3984w3).

Some medical professionals have opted out of the system themselves and are advising patients to do the same (www.thebigoptout.org). For those that do there might be an alternative.

Internet powerhouse Google, which is already viewed as a medical resource by many, is looking to put control into the hands of the patient with its long anticipated Google Health project, which the company's head of search Marissa Mayer says will materialise in the US in "early 2008" (www.tinyurl.com/yw94v4).

Previews hint that the initiative will combine Google's data storage and search capabilities to offer consumers the chance to create and control a portable, personalised Google Health profile.



Commentators say users will add personal information and upload records from securely connected GP or pharmacy systems. Based on the details, Google will create a personal health guide including information on drug interactions, treatments and preventive measures, with signposting to local professionals where appropriate.

A taste of what might come emerged last week with the news that up to 10,000 people are to participate in a pilot of Google Health. During the trial, data about prescriptions and allergies, for example, will transfer between patients' Google profiles and the hospital's own system (www.tinyurl.com/2qtgc6).

There will doubtless be arguments over privacy and security, but if Google sniffs a profit in creating a database of medical records, then it thinks enough people have enough faith in the familiar search engine to overcome those concerns.

What do you think?

Email thawkins@cmpmedica.com

... your views on the C+D website ...

Dispensing doctors slam pharmacy MAS

Posted by David Baker, on 22/02/2008 17:33

"As CEO of the DDA I must correct the impression you have of our view of minor ailment schemes in pharmacy. We are NOT against them, as long as they are an addition to current services. The evidence base is not there for pharmacy based schemes yet and I agree with Sheila and Alastair that a national scheme would be a disaster."

Push for national obesity service

Posted by Mukesh Lad, on 22/02/2008 14:36

"For smoking cessation, I think the next big service that pharmacies can help support is obesity. Coventry pharmacists have shown it can be done, so all our pharmacy bodies should be engaging with the Department of Health to produce a national obesity service or do larger pilots throughout the country."

Iron bar attacker back in RPSGB dock

Posted by Ken Sims on 21/2/08 19:28

"I don't believe it. This report means that 30 years after we tried to get pharmacists whose lack of competence put patients at risk suspended from practice summarily, that nothing has changed, so long as they appeal? This is madness. Only in Britain could this happen."

Increase in crystal meth

Posted by Anonymous on 25/2/08 12:57

"Will this give the MHRA the ammunition to reclassify pseudoephedrine and ephedrine as POMs? It would be such a shame if it does, because these products are safe and effective medicines used by thousands of patients every year. As pharmacists, surely we want more products available for us to recommend, not fewer."

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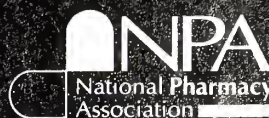
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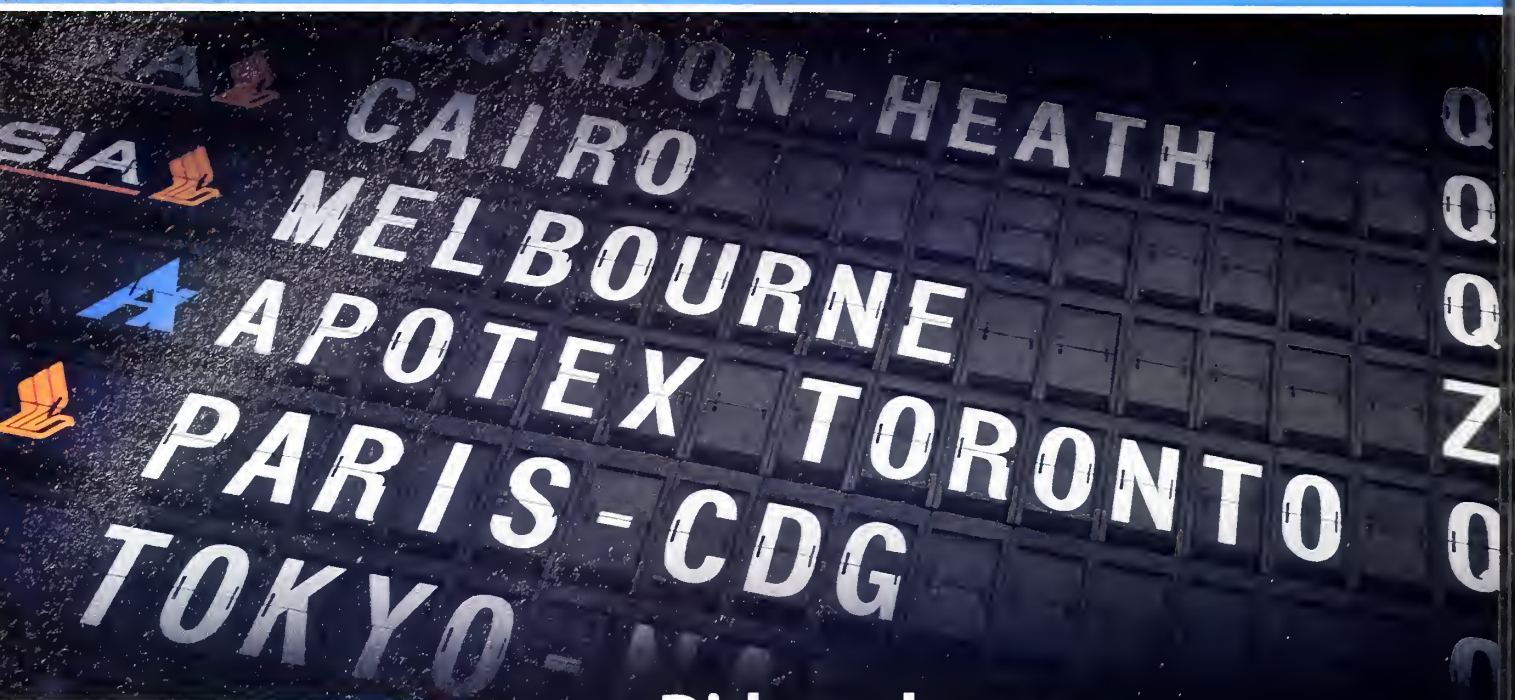
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